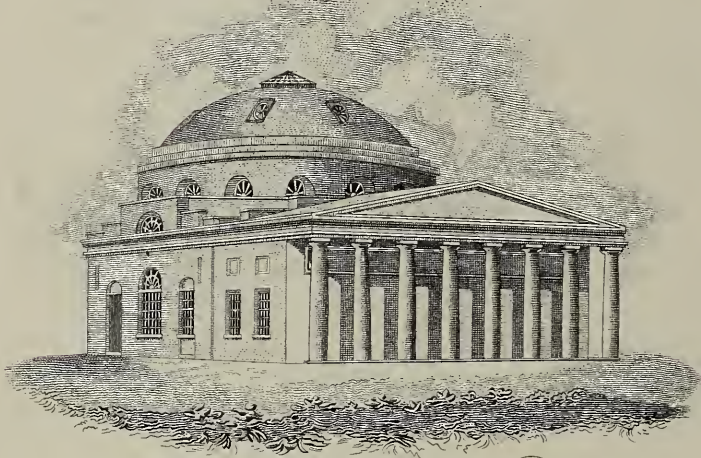


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The Journal

of the

Michigan State Medical Society

Published Under the Direction
of the Council

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VOLUME 44
1945



ERTRONIZE THE ARTHRITIC

To *Ertronize* the arthritic patient, employ ERTRON in adequate dosage over a sufficiently long period to produce beneficial results. Gradually increase the dosage to the toleration level. Maintain this dosage until maximum improvement occurs.

Ertronize early and adequately for best results.

ERTRON* alone—and no other product—contains electrically activated, vaporized ergosterol (Whittier Process).

Supplied in bottles of 100 and 500 capsules.

**ETHICALLY PROMOTED
NUTRITION RESEARCH
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CHICAGO**

*Reg. U. S. Pat. Off.

ERTRON PARENTERAL

For the physician who wishes to reinforce the routine oral administration of Ertron by parenteral injections, Ertron Parenteral is available in packages of six 1 cc. ampules. Each ampule contains 500,000 U.S.P. units of electrically activated, vaporized ergosterol (Whittier Process).



ERTRON

Progressive Michigan Medicine

"The Michigan State Medical Society feels it a great privilege and honor to serve our medical veterans upon their return to civilian life," stated President A. S. Brunk, M.D. in his presidential message to the membership last month, when he outlined the State Society's newest and most progressive project—the Medical Veterans' Readjustment Program.

This program's threefold activity will assist medical officers with problems of (a) postgraduate work; (b) relocation; and (c) finances.

A counselor—a Doctor of Medicine—is to administer the program which was created by the 1944 MSMS House of Delegates. The project will be under the direction of the MSMS Council. Universal enthusiasm for this latest activity of the State Society in extending a hand of help as well as welcome to officers of the Medical Corps as they are separated from military service has been voiced on all sides by members of the medical profession on the home front.

The 1944 House of Delegates instructed that a per capita assessment of \$5.00 be levied in 1945 on every active member of the State Society to defray the expenses of this postwar veterans' program.

MMS—Another Pioneering Project of Michigan

"In five years Michigan Medical Service, biggest voluntary venture into the field of medical economics, has become the nation's No. 1 set-up of its kind" stated the *Detroit Free Press* in a feature article on Sunday, October 15, 1944.

This professionally sponsored voluntary plan has proven to approximately 700,000 people of Michigan that they can obtain complete surgical service, including obstetrics and laboratory service, for themselves and their families when the need arises, without governmental intervention. And of the close to 700,000 subscribers, approximately 200,000 persons have received surgical services for which almost \$8,500,000 was paid.

The Michigan State Medical Society spent thousands of dollars over a period of ten years investigating the possibilities of extending medical service to groups ordinarily unable to afford it. Its pioneering work and determination to serve the people has been rewarded by today's amazing results. Michigan Medical Service is able to insure complete payment of a subscriber's surgical bills for disease or accident for the modest sum of sixty cents a month. People sign up with their employer, church, club, farm co-operative, etc., in groups of ten or more.

Michigan Medical Service stands a most suc-

cessful example of the medical profession's oft repeated contention that the people—who want medical security—prefer to obtain it through a voluntary program sponsored by the medical profession in whom they have faith. Michigan Medical Service represents five years of hard work, many worries and much heartache especially on the hardy and daring men who served and who are still serving on its Board of Directors. But the task has been worthy, well worth the grief of Michigan's medical pioneers. Their vision, determination, and labor for the good of the people are bringing forth fruit a hundred-fold. The chief by-product of Michigan Medical Service is co-operation by lay groups in this and many allied endeavors.

Our Outstanding Postgraduate Medical Education Program

Another laudatory accomplishment of the Michigan medical profession has been its program of postgraduate medical education. Long ago, solid foundations for the present successful intra and extra-mural courses were laid by James D. Bruce, M.D., Ann Arbor, and the members of his postgraduate committees of the State Society. The fame of Michigan's "P. G. Plan," has spread and has been emulated throughout the land. Its work will be best appreciated in the immediate future, when our Michigan medical veterans return from military service seeking a continuation of their medical studies. The Michigan program is ready for this test of its ability and scope. Success and satisfaction again will be spelled out for Michigan's outstanding postgraduate medical education program.

Radio Advertising by the Michigan Medical Profession

The purchase of time over the air to present a message about medicine and a "plug" for the medical profession and its philosophy would have been a revolutionary thought ten years ago. But the Michigan State Medical Society did this, to the tune of \$10,000, in 1944. It presented two five-minute broadcasts per week, for 13 weeks, over twelve Michigan radio stations covering every section of the state. The 26 five-minute presentations were dramatized sequences of an educational nature. The theme of the skits depicted the benefits TO THE PUBLIC of the present and proposed medical availabilities as contrasted to federal or state bureaucratic compulsory forms of medical practice. Professional

(Continued on Page 8)

Sleep, baby, sleep



BABY has had a good lunch and is sleeping comfortably, thanks to the flocculent, easily digested milk curds produced by 'Dexin'. Nor is it likely that distention, colic and diarrhea will disturb baby's sleep, for the high dextrin content diminishes intestinal fermentation.

Mother is happy because 'Dexin' is so easy to prepare. It is readily soluble in hot or cold milk, and is so palatable without excess sweetness that baby takes other bland supplementary foods willingly. 'Dexin' gives mother extra time for herself. Containers of 12 ounces and 3 pounds. 'Dexin' Reg. Trademark

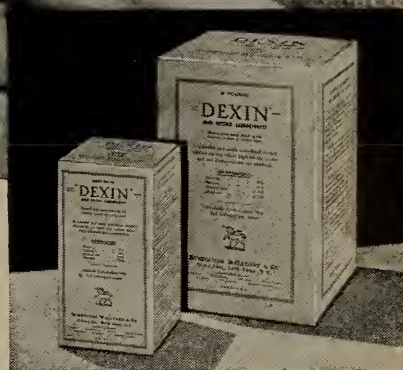
Literature on request



BURROUGHS WELLCOME & CO. (U.S.A.) INC.
9-11 East 41st Street, New York 17, N. Y.

JANUARY, 1945

Say you saw it in the Journal of the Michigan State Medical Society



'Dexin' does make a difference

COMPOSITION

Dextrins	75%
Maltose	24%
Mineral Ash	0.25%
Moisture	0.75%

Available carbohydrate 99%
115 calories per ounce
6 level packed tablespoonfuls
equal 1 ounce

Dexin

HIGH DEXTRIN CARBOHYDRATE



PROGRESSIVE MICHIGAN MEDICINE

(Continued from Page 6)

radio actors of high histrionic ability were engaged, the technical work being performed by a high-class advertising agency. Each sequence was followed by the following statement made by the announcer:

"American Medicine, the private practice of which represents the cumulative knowledge of decades, the heritage of centuries, the sacrifices and discoveries of countless individuals has made the United States the healthiest country in the world. Spinal meningitis, diphtheria, smallpox, typhoid fever, and other fatal diseases, scourges of yesteryear, are today either preventable or curable, a credit to the tireless efforts of the American Medical Profession. Thirty-seven states now have voluntary prepayment medical or hospital plans developed by the medical profession and the hospitals.

No theoretical plan, Government-controlled and operated, and paid for by you, should replace the tried and proven system of private practice now in use."

Michigan's experiment in advertising of the medical profession may have appeared revolutionary but it has been fruitful. Much good has been accomplished. Some of the people now know there are TWO sides to the question of distribution of medical care, and further, that the solution does not lie in the visionary panaceas offered by self-seekers or dreamers knowing nothing of medical practice, but in a thoughtful painstaking evolution being worked out by the medical profession of the United States. Many people now realize for the first time that private practice, aided by supplementary features—such as Michigan Medical Service with its 700,000 subscribers—are to be preferred, *for their own good* than more compulsion and further taxes out of Washington, D. C.

Michigan Health Council

When the Michigan Health Council was first conceived in July, 1943, even the sponsors did not envision completely the great and potent force for good which this organization has been and will continue to be. The Health Council is an educational vehicle, one that co-ordinates the necessary work of a number of agencies interested in ascertaining just what kind of health services the public wants, in procuring those services for the people, and in telling them how it is available.

An outstanding activity of the Michigan Health Council in 1944 was the Michigan Survey of Public Opinion, which verified the fact that the people look to the medical profession for guidance and action in the problem of complete distribution of medical care. The Health Council Survey mirrored the likes and dislikes of the people and indicated clearly how the medical profession could make itself into an almost perfect group, enjoy-

ing better public relations than any other profession, business or trade.

The future program of the Michigan Health Council, to which the Michigan medical profession lends its full co-operation, would indicate that this educational agency will be able to assist the medical men of this state to attain the goal of perfection indicated as necessary in the Michigan Survey.

* * *

Progressive Michigan medicine still strives for better things in behalf of the people it serves. It does not rest on its laurels. It seeks more progress.

ON THE RUN . . .

Excessive loss of potassium in chronic nephritis may result in episodes of flaccid paralysis of the extremities and low T waves in the electrocardiogram.

* * *

Patency of the ductus arteriosus after the age of seventeen is associated with an average reduction in life expectancy of about twenty-five years.

* * *

Wiring and electrothermic coagulation are being used successfully to inactivate syphilitic saccular aneurysms of the aorta.

* * *

Striking results in lowering toxemia, checking pustulation and effecting minimal scarring were noted in twelve cases of smallpox treated with sulfathiazole.

* * *

The application of a modified vanGieson stain (0.2 per cent acid fuchsin and a half saturated solution of picric acid in water) to a fresh burn after removal of the blister, has been suggested to determine the depth of tissue destruction. Living dermis stains a bright red while dead tissue takes up the picric acid, staining yellow.

* * *

A mild benign form of chronic hepatitis is likely after catarrhal jaundice.

* * *

Pernicious anemia is an extremely rare sequela to subtotal or total gastrectomy.

* * *

In nephritics, when the phenolsulphonphthalein excretion is below 5 per cent in the first fifteen minutes, survival for more than one year is unusual.

* * *

Multiple primary cancers of the colon may occur simultaneously or successively over a period of years.

* * *

Avian and mammalian embryos exhibit a much higher susceptibility to infection than adult tissues.

* * *

Extreme irritation of the peritoneum, as in perforated peptic ulcer, causes almost immediate cessation of all abdominal sounds.

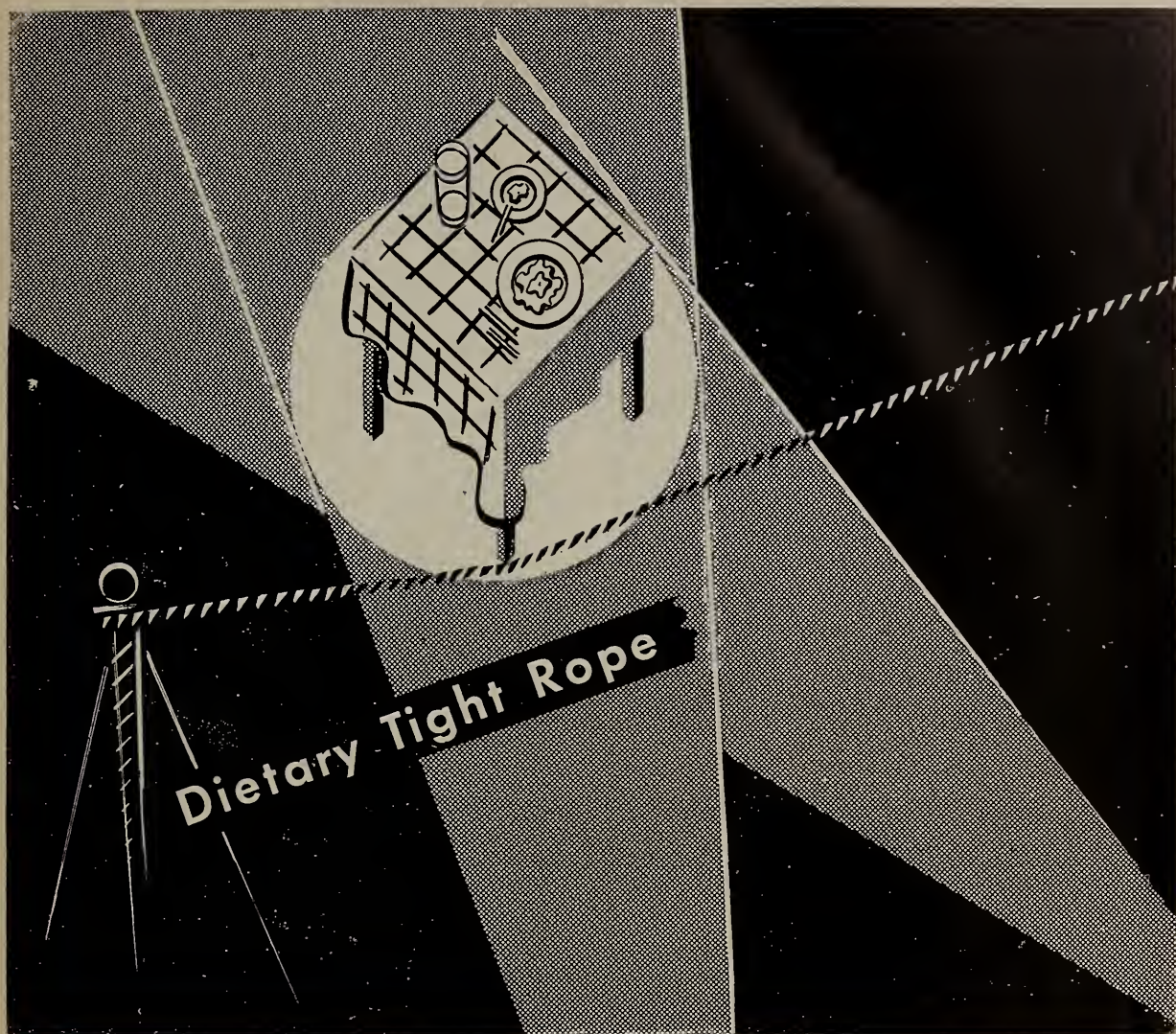
* * *

Children from six to nine years of age have exactly twice as many colds as children from ten to thirteen, and three times as many as those between fourteen and seventeen years of age.

* * *

A progressive diminution of blood urea has been noted in patients with acute or subacute uremia following the daily intramuscular administration of 2 to 5 mgm. desoxycorticosterone acetate.

Selected by W. S. REVEÑO, M.D.



The restricted therapeutic diet in metabolic, allergic, cardiovascular, gastro-intestinal, or renal disease may force patients to "walk the tight rope" of vitamin adequacy. Too often they lose their dietary balance, with the result that nutritional deficiency is superimposed on the primary disease.

An Upjohn vitamin product, prescribed with limited diets, often helps the patient retain a surer vitamin footing. One dose daily of the indicated high potency, economical Upjohn vitamin product is usually adequate for effective dietary supplementation.

U P J O H N V I T A M I N S

Upjohn
KALAMAZOO, MICHIGAN

FIGHT INFANTILE PARALYSIS . . . JANUARY 14-31

JANUARY, 1945

Say you saw it in the Journal of the Michigan State Medical Society

You and Your Business

THE MICHIGAN SURVEY OF PUBLIC OPINION SHOWS

QUESTION: If you were asked to choose, which would you prefer . . . ?

1. Voluntary pre-payment program sponsored by the medical profession..33.7% (was the answer)
2. Government controlled...15.5% (was the answer)
3. Regular insurance.....13.4% (was the answer)
4. Payment for service at time rendered.....26.6% (was the answer)

When they know there is a choice, the people decisively favor a pre-payment plan sponsored by you.

Except That . . .

The survey also shows that three out of four haven't heard of *Michigan Medical Service*, sponsored by the Michigan State Medical Society.

QUESTION: Have you ever heard of a medical service plan sponsored by the medical profession?

- No75.4% (was the answer)
Yes23.8% (was the answer)

It is a calamity that most of the voters of Michigan do not know there is an existing alternative to compulsory government prepayment.

SOCIAL SECURITY ON THE STATE LEVEL

Social Security proposals were not generally well received by voters at the recent state elections.

In the State of Washington a broad and immensely costly pension plan was overwhelmingly defeated. A ham and eggs proposition (known as the \$60 at 60 plan) was decisively downed in California. In Oregon a scheme to replace old age assistance by retirement annuities and disability insurance was likewise defeated. Arkansas voted against a \$5,000,000 hospital building program. In each case, cost to the taxpayers appears to have been the decisive factor.

From Massachusetts comes word that the advisory committee to the legislature, which has been holding hearings on health insurance for nearly a year, will recommend no action for the present. Continuance of the committee will be requested for the purpose of continuing its study when conditions return to normal.

Michigan an Exception

The trend to conservatism, cutting across party lines, has, however, some exceptions—one of which is Michigan. A broad social security proposal may come before the people at the April election. The measure is not soundly drawn and includes medical and hospital care. No predictions as to the outcome can be made until the situation has been further clarified.

Colorado is another exception—in that state a meas-

ure appropriating \$1,500,000 for pensions of \$45 monthly was approved by voters!

Of the four states taxing employes for unemployment insurance, in addition to the Federal tax on employers, Rhode Island already has a health insurance plan, there is no report of pending activity in New Jersey, and Alabama is said to be definitely under the control of an economy-minded administration. California is the fourth state.

* * *

CHICAGO MEDICAL SOCIETY SECOND ANNUAL CLINICAL CONFERENCE

The Chicago Medical Society is holding its Second Annual Clinical Conference at the Palmer House, Chicago, on February 27-28 and March 1, 1945. The sponsoring of this annual clinical conference for physicians of the Middle West has become an important function of the Chicago Medical Society following its inauguration last spring.

Chicago is a great medical center, probably one of the world's greatest, with abundant clinical material and clinicians of national reputation. The program presented at the first conference, last spring, was enthusiastically received by the several thousand physicians who attended. The Committee is already under way in securing speakers on important subjects for the 1945 conference. Exhibits, both technical and scientific, will be greatly increased.

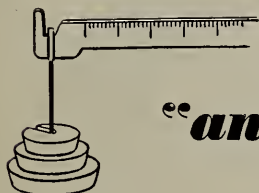
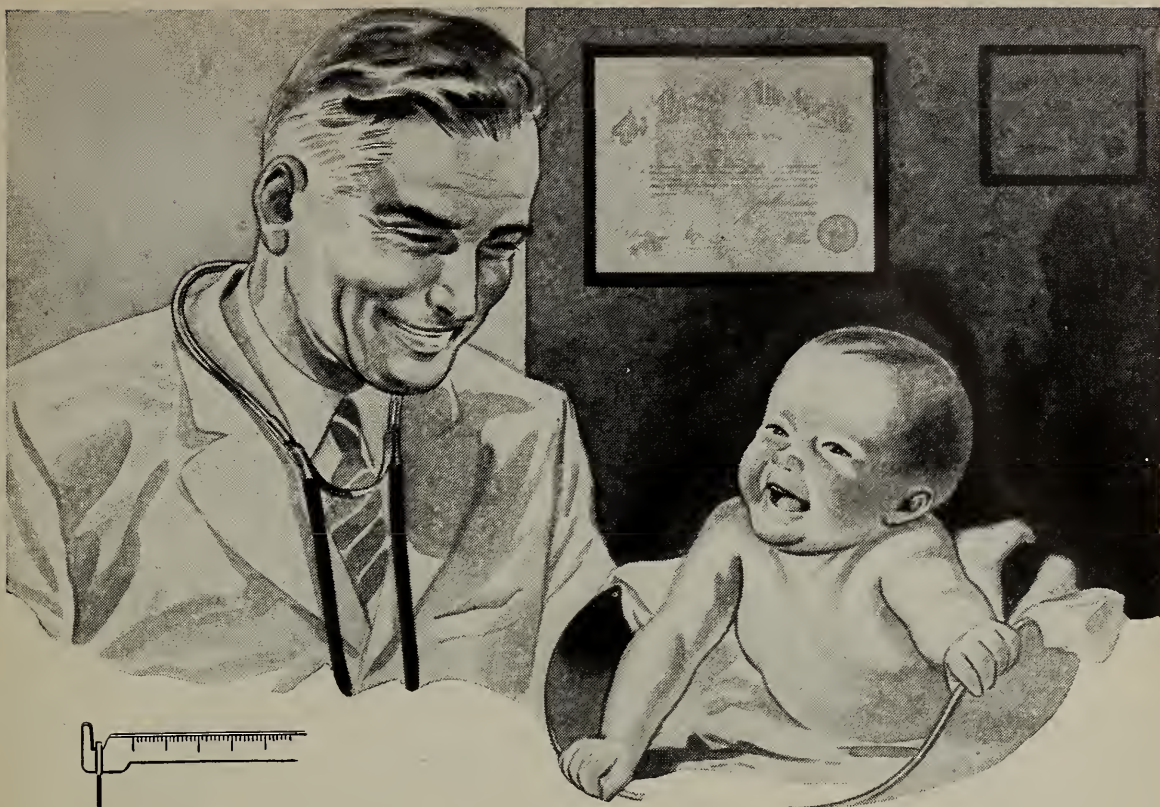
BARUCH COMMITTEE ON PHYSICAL MEDICINE

The Administrative Board of the Baruch Committee on Physical Medicine has announced the granting of an additional sum of \$185,000 for further advancement of the program in physical medicine and the physical rehabilitation of those disabled in the war. Grants go to seven colleges to establish continuing courses. Mr. Baruch was especially interested in the field of electronics as applied to medicine. Doctor Frank H. Krusen, director of the Baruch Committee announced that the Administrative Board does not contemplate any further large grants, but will turn its attention to the development of the centers already established. He stated that Mr. Baruch's gifts had served as a means of providing prompt co-ordination of the entire program for rehabilitation of our wounded, and for the provision of the trained personnel needed to activate this program.

CONFERENCE OF STATE SECRETARIES AND EDITORS

The annual conference in Chicago, November 17 and 18, 1944, devoted most of its energies to public relations. Talks were given by officers of the American Medical

(Continued on Page 16)



***"another three ounces –
just right, young man"***

...A familiar statement by physicians prescribing Biolac for infants deprived of human milk.

The protein level of Biolac assures an adequate supply for growth and health, with small, soft curds. The adjusted milk fat facilitates digestion and assimilation with greater freedom from "fat upsets"; and the ample lactose content assures a soft natural stool formation. The adequate proportions of lactose, iron, and vitamins A, B₁, B₂ and D eliminate the need for time-consuming calculations of extra formula ingredients. Indeed, Biolac (supplemented with vitamin C) provides *completely* for infant nutritional requirements throughout the bottle period.

BORDEN PRESCRIPTION PRODUCTS DIVISION
350 MADISON AVENUE • NEW YORK, 17, N. Y.



Easily calculated... Quickly prepared. 1 fl. oz. Biolac to 1½ fl. oz. water per pound of body weight.

Biolac is a liquid modified milk, prepared from whole and skim milk, with added lactose, and fortified with vitamin B₁, concentrate of vitamins A and D from cod liver oil, and iron. Evaporated, homogenized, and sterilized, vitamin C supplementation only is necessary. Biolac is available in 13 fl. oz. cans at all drug stores.



Biolac

—“BABY TALK” FOR A GOOD SQUARE MEAL

CONFERENCE OF STATE SECRETARIES AND EDITORS

(Continued from Page 14)

Association reviewing the work of the Association. Especial stress was made on the necessity for better contacts with Congress in the nature of furnishing information so needed in proper action on the numerous matters that affect the practice of medicine, and the care of the sick.

Plans for the postwar rehabilitation of the doctors in the military are going forward in quite detail. Rehabilitation of veterans is assuming major proportions of study and consideration. There is a broad program of rehabilitation and physical methods in a national Fitness Program that has sufficient financial backing and is just waiting for the spark from the medical profession that will integrate it.

Medical Service plans, and their essential place in the distribution of medical care are assuming more and more importance. Much of the discussion centered around this approach to the delaying of federal medicine.

Our own Andrew S. Brunk, M.D., President of the Michigan State Medical Society, spoke on Radio Broadcasting by the Medical Profession, and stimulated an active interest. Postgraduate medical training for postwar transition back to private practise was outlined and is being co-ordinated through a questionnaire sent to every man in military service, asking what kind of courses he wants.

1945 ANNUAL SESSION, MSMS

S. W. Insley, M.D., President-elect of the Wayne County Medical Society, has been appointed as chairman of the Detroit Arrangements Committee for the 1945 Postgraduate Conference on War Medicine—the 80th Annual Session of the Michigan State Medical Society—which will be held in Detroit at the Book-Cadillac Hotel, September 19-20-21. Twenty-five out-of-Michigan guest essayists, as well as a number of illustrious Michigan speakers, will be on the 1945 program.

Harry F. Dibble, M.D., Detroit, is chairman of the Committee for Hotels for the 80th Annual Session.

* * *

DUES AND ASSESSMENTS

The 1944 House of Delegates of the Michigan State Medical Society voted a \$5.00 assessment for a postwar Medical Veterans' Readjustment Program which will include the employment of a postwar counselor (a Doctor of Medicine) who will consider the problems of our returning military members connected with (a) relocation; (b) postgraduate medical education; (c) finances.

The 1944 House of Delegates also voted to continue the special \$10.00 per capita assessment for public education purposes which proved its value during the past twelve months. This assessment will be earmarked for the exclusive purposes of public educational programs.

These assessments will be effective January 1, 1945, payable on or before April 1, 1945 and will be in addition to the annual twelve dollar dues of the State Society.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States and Canada on Saturday, February 3, 1945, at 2:00 p.m.

Arrangements will be made so far as is possible for candidates in military service to take the Part I examination (written paper and submission of case records) at their places of duty, the written examination to be proctored by the Commanding Officer (medical) or some responsible person designated by him. Material for the written examination will be sent to the proctor several weeks in advance of the examination date. Candidates for the February 3, 1945, Part I examination, who are entering military service, or who are now in Service and may be assigned to foreign duty, may submit their case records in advance of the above date, by forwarding the records to the Office of the Board Secretary. All other candidates should present their case records to the examiner at the time and place of taking the written examination.

The Office of the Surgeon-General (U. S. Army) has issued instructions that men in Service, eligible for Board examinations, be encouraged to apply and that they may request orders to Detached Duty for the purpose of taking these examinations whenever possible.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

DETROIT'S MEDICAL SCIENCE CENTER

Wendell W. Anderson, president of the Medical Science Center of Wayne University, has been named chairman for the first cycle of the Medical Center's fund-raising campaign.

Goal of the first cycle will be approximately \$10,000,000. The four buildings to be constructed in the first cycle program are the Halls of the Medical Sciences, to house the Wayne University College of Medicine, the College of Pharmacy, the School of Mortuary Science, and allied programs; a university hospital for teaching and research; a classroom, administration and dormitory building for the recently authorized College of Nursing; and a powerhouse, laundry and service building.

Eventual goal of the Medical Science Center campaign is \$50,000,000, of which approximately \$20,000,000 will be for construction and equipment of buildings, and \$30,000,000 for the endowment of program and research.

The City Plan Commission has approved a 53-acre, fifteen-block site for the Medical Science Center situated east of the Art Center. The Corporation Counsel has begun the condemnation of the first three blocks of this site.



**GROOVED FOR
ACCURATE DOSAGE**



CHILDREN'S TABLETS

SULFATHIAZOLE 0.25 Gm.
(Pitman-Moore)

In suspected cases of pneumonia, early institution of chemotherapy is stressed "while the specific, offending organism is being determined."*

Children's Tablets Sulfathiazole are specially designed for your convenience in prescribing for young patients. Each tablet contains 0.25 Gm. sulfathiazole,

pleasantly flavored, friable, grooved for accurate division of dosage.

This is one of a comprehensive line of medicaments in tablet form, carefully designed in composition, appearance, flavor and dosage for convenient administration to, and ready acceptance by, the child patient.



*Tripoli, C. J.: The Sulfonamides in Internal Medicine, New Orleans Med. and Sur. J., 96:455-461 (April) 1944

PITMAN-MOORE COMPANY

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

Division of  *Allied Laboratories, Inc., • Indianapolis 6, Indiana*

JANUARY, 1945

Say you saw it in the Journal of the Michigan State Medical Society

War Medicine

MEDICAL SUPPLY ITEMS

The volume of items processed by the Medical Department exceeded that of the Quartermaster in September of this year. The Medical Department processed 144,000 line items for overseas as compared to Quartermaster's 141,000. Only Ordnance and Engineers exceeded the Medical Department. A like comparison is evident for domestic shipments. The Medical Department processed 313,000 domestic line items and was only exceeded by Ordnance and the Quartermaster.

STRENGTH OF THE ARMY MEDICAL DEPARTMENT

In connection with the recent announcement that the Army is no longer recruiting physicians, the following figures are of interest:

The Army Medical Department has grown from 8,010 at the beginning of World War II until it now numbers 680,891. Of this number approximately 44,651 are in the Medical Corps, 14,948 in the Dental Corps, 2,012 in the Veterinary Corps, 2,364 in the Sanitary Corps, 15,078 in the Medical Administrative Corps, 59 in the Pharmacy Corps, 40,305 in the Army Nurse Corps, and there are 559,327 enlisted men, 813 Physical Therapy Aides, and 1,334 Hospital Dietitians.

GENERAL LULL DEDICATES VAUGHAN HOSPITAL

At special ceremonies held in Hines, Illinois, Major General George F. Lull, USA, Deputy Surgeon General, dedicated Vaughan General Hospital, which will specialize in medicine and psychiatry.

Colonel Victor Clarence Vaughan, in whose memory the hospital has been named, was one of the leading bacteriologists and toxicologists of his day. He was commissioned a Major in the U. S. Army during the Spanish-American War and was a member of the commission headed by Walter Reed to study the cause and prevention of typhoid fever, then epidemic in military camps.

During the World War, Colonel Vaughan served in the Office of The Surgeon General and was on the executive committee of the general medical board of the Council of National Defense. He served as president of the American Medical Association and of the American Tuberculosis Association. He was awarded the Distinguished Service Medal for his outstanding work in epidemiology and was made a knight of the Legion of Honor by the French government. He died in 1929.

Victor C. Vaughan was formerly Dean of the Department of Medicine, University of Michigan.

WHOLE BLOOD SHIPMENTS START IN PACIFIC

Whole blood shipments to the Pacific battlefield started on November 16. The blood is collected in San Francisco, Oakland and Los Angeles by the Red Cross,

typed by Army and Navy laboratories, and flown by Navy plane across the Pacific for joint use by the armed forces.

Although West Coast shipments of ice-packed whole blood started on a small scale, over 200 pints a day are now being called for to make the 3-day Pacific flight. Meanwhile, daily flights of whole blood donated in New York, Boston and Washington, cross the Atlantic within 24 hours for use in the European theater of operations.

RESULTS OF ARMY RECONDITIONING

In a little over a year of operation reconditioning has been developed to a stage where twelve thousand patients a week are being discharged to duty from the Army hospitals in the continental United States.

This statement, made by Colonel Augustus Thorndike, MC, Director of the Reconditioning Consultants Division, gave added point to his talk on the Army's reconditioning program before The Military Surgeons.

In summing up its results Colonel Thorndike said that the reconditioning program as now operating in Army hospitals has accomplished its mission of reducing the hospital readmission rate and the average period of hospitalization; has returned better conditioned soldiers to duty; and is returning disabled veterans to civilian life better fitted physically and mentally and better prepared to resume an independent, self-supporting existence.

In short, Colonel Thorndike said, reconditioning helps patients to help themselves!

* * *

ARMY MALARIA CONTROL THREEFOLD PROBLEM SAYS GENERAL SIMMONS

The Army has made great progress in the control of its No. 1 disease hazard, malaria, according to Brigadier General James S. Simmons, USA, Chief of the Preventive Medicine Service. The problem has two aspects—control in base areas and protection of troops in combat. The first is primarily mosquito control, and specially trained personnel are required to produce effective results. The malaria control organization in the Army Medical Department includes medical officers trained in malariology, and small survey and control units headed by parasitologists, entomologists and sanitary engineers.

The second aspect—protection of troops in forward and combat areas—depends upon individual measures of protection in addition to mosquito control, according to General Simmons, and strict malaria discipline must be established and enforced. Soldiers must be drilled in the use of repellents, sleeping nets, protective clothing and insecticide sprays in the same way they are trained to use combat weapons.

Concerning the third aspect—the possible spread of
(Continued on Page 20)



The Largest Exclusive Health and Accident Company in the World!

Year after year this name—*Mutual Benefit Health and Accident Association of Omaha*—becomes more and more familiar to the doctors of America as they complete claim blanks for patients who have been ill or injured.

No doubt, many of your own patients are our policyholders—for more men and women have turned to us for income protection against disability than to any other exclusive health and accident company in the world. The very fact that these men and women have had the foresight to provide for their financial needs in case of sickness, accident or hospitalization shows their dependability and their feeling of responsibility. Their policy with us helps to protect you.

Here in Michigan we have paid many millions of dollars in benefits. Because claims are handled direct from our office in Detroit, payment is always made promptly . . . within 24 hours. We can, if you wish, help make an assignment available for payment of your bill from your patient's claim. Your help to our policyholders in completing their claim blanks is fully appreciated, and we are anxious to co-operate with you in every way possible. Please call us at any time we can be of help.

EARL B. BRINK AGENCY

1221 Book Building

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Branch offices in all principal cities of Michigan

Tune in! "FREEDOM OF OPPORTUNITY"—Every Tuesday Night—7:30-8:00 p. m.—CKLW. Powerful, dramatic, true life stories of America's greatest stars! Heard coast-to-coast over 217 stations of Mutual Broadcasting System. Sponsored by Mutual Benefit Health & Accident Association of Omaha.

ARMY MALARIA CONTROL

(Continued from Page 18)

malaria in this country by returning soldiers—General Simmons said that members of the armed forces who have had malaria will be given sufficient treatment to render them free from demonstrable parasites before they are discharged. In addition, men who have had malaria or served in malarial regions are advised to seek prompt medical attention and have a blood smear for malarial parasites in case of illness with fever.

However, prevention of malaria in this country, as elsewhere, depends essentially upon the control of the malaria-carrying mosquito.

VIRUS TYPE EQUINE ENCEPHALOMYELITIS

All three types of equine encephalomyelitis viruses known to be present in the Western Hemisphere are capable of producing fatal encephalitis in man, according to Colonel Raymond Randall, VC, of the Army Veterinary School at Washington, D. C. In a paper presented at the annual meeting of the Association of Military Surgeons, Colonel Randall pointed out that the relatively high mortality rate of the human disease emphasizes the importance of this horse disease from the public health standpoint.

In 1941 more than 3,000 human cases were reported in the United States and Canada. Most of them occurred in North Dakota, South Dakota, Nebraska and Canada. North Dakota having the highest incidence with 1,080 cases and 96 deaths. Cases were also reported from California and Washington. The mortality rate among the human cases varied in different areas from 8 to 20 per cent, adult male farm workers having the highest incidence. This is in contrast with the Eastern type infection which in the outbreaks thus far recorded was predominantly a disease of children and had a mortality rate of approximately 75 per cent. In many instances during the midwestern epidemic of 1941 the Western type encephalomyelitis virus was isolated and it appears that the St. Louis encephalitis virus played a very minor role in the outbreak.

The evidence is ample that equine encephalomyelitis is transmitted by insects, particularly mosquitoes, and its control involves anti-mosquito measures. Horses and mules may be protected against the disease by the annual administration of chick tissue vaccines. A vaccine suitable for human use has been developed in the Army Veterinary School, Colonel Randall said, and can be made available if indications for its use should develop.

PAY ALLOWANCES FOR WOMEN MEDICAL OFFICERS

Legislation under which women officers of the Army Medical Corps will be entitled to receive the same pay allowances for their dependents as are paid to all other commissioned personnel of the Army became effective on October 1.

An act authorizing the commissioning of women phy-

sicians in the Medical Corps was approved in April, 1943, and provided that they should "receive the same pay and allowances and be entitled to the same rights, privileges and benefits as members of the Officers Reserve Corps of the Army." The Comptroller General subsequently ruled that they were not entitled to allowances for dependents.

The new law, designed to meet the Comptroller General's objections, is not retroactive to the date of women officers' commissions. The dependents for whom allowances may be paid are "husband, a child or children, or a parent or parents in fact dependent" upon the officer "for their chief support."

Approximately 75 women have been commissioned to date in the Medical Corps.

CRITICAL NEED FOR ARMY NURSES CONTINUES

Out of 27,000 recruiting letters sent by the Army Nurse Corps to nurses classified as 1-A for military service by the War Manpower Commission, only 710 replies have been received, and less than a third of these are from nurses qualified for commissions.

While the drive to recruit Army nurses lags, the number of patients being evacuated from overseas to the United States has been increased almost 300 per cent. In addition the overseas requirements for nurses continues to grow, with the quota for the month of December alone set at approximately 1,000 nurses.

125 MICHIGAN DOCTORS NEEDED BY THE NAVY

The Army recently announced a cessation of their procurement of physicians. On the same day, the Navy emphasized its serious need for 3000 additional medical officers. Michigan's share is approximately 125. This 3000 will not fill the authorized quota desired by the Navy but will take care of its emergency needs. Any Michigan doctor interested in obtaining a commission in the Medical Corps of the United States Navy, who may secure clearance from the Procurement and Assignment Service, is urged to contact the Office of Naval Officer Procurement, 1249 Washington Boulevard, 9th Floor, Book Building, Detroit 26, Michigan.

Commander D. F. Hoyt, (MC), USNR
Senior Medical Officer.

* * *

NEW HOSPITAL CAR

On November 13, the first of a new type hospital car for use in the United States was opened for inspection in Washington, D. C.

These new unit-type cars are not converted pullmans, but are designed and built as hospital cars. They are ten feet longer, are air-conditioned, accommodate 38 patients and attendant personnel. Each includes two rows of triple-tiered beds, two compartments with three beds each, a stainless steel kitchen equipped with refrigeration, ice cream cabinet and coal range; a receiving room with four-foot side doors for loading and

(Continued on Page 22)

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NEW HOSPITAL CAR

(Continued from Page 20)

unloading litter patients; two roomettes, each with toilet and shower, for the medical staff or seriously ill patients; and a baggage compartment. The car also carries a modern pharmacy unit and sterilizing equipment and in case of emergency either the receiving room or one of the roomettes can be converted quickly into an operating room.

The Glenon-type, steel-frame beds are adjustable and unoccupied center bunks can be dropped to provide seating accommodations for ambulatory patients.

Six more of these cars were to be put into operation in November, 18 in December and 75 during January, February and March of 1945—bringing the total to 100, in addition to the 120 converted hospital cars now in use.

MEDICAL RECORD OF DISCHARGED VETERANS

"When discharged veterans come to a civilian practitioner for medical advice or treatment, how may he obtain a health and medical history of the person while he was in military service?" asked a physician in civilian practice recently.

The War Department has issued a regulation which authorizes the Commanding Officer of any hospital, where a member of the armed forces may have received treatment, to release information from his or her medical records to "registered civilian physicians, on request of the individual or his legal representative, when required in connection with the treatment of the member or former member of the armed forces" (Regulation No. 40—590).

The information given must be treated as confidential.

The Navy Department and the Veterans' Administration undoubtedly will co-operate in the same manner.

* * *

ARMY LIFE-SAVING

Something vital not apparent in the periodic casualty lists of this war is the remarkably high percentage of wounded who recover and the large number who get back into action. The record is such that Surgeon Gen. Norman T. Kirk describes the work of American Army surgeons as "unparalleled in the history of warfare and is little short of miraculous."

He told the Scientific Assembly of the District of Columbia Medical Society Friday that "the survival rate among our wounded at the present time is higher

than it ever has been in any army in any war at any time."

Public attention has been attracted to the spectacular accomplishments of penicillin, the availability of which, Gen. Kirk said, has permitted "surgical procedures that would otherwise not be possible. Deaths in a recent series of cases of gas gangrene treated with the drug were one-third of the average among gas gangrene victims in the first World War.

But the record is not confined to the merits of new drugs, remarkable though they are. Development of treatment of surgical technique has had much to do with the low rate of permanent disability and the speeding of recovery.

There is also the unexcelled skill of the medical men in our armed forces which, when confronted with this great emergency, was able to draw upon a profession which had progressed notably in our cherished way of life. It is something well to remember as what amounts to socialization of medicine is advocated.

The system which some theorists would undermine is paying priceless dividends in American lives.—Editorial in the *Flint Journal*, October 6, 1944.

Army casualties through November 22, 1944, were 474,898, an increase of 13,840 since the report which covered the period to November 15. Navy casualties total 77,120, an increase of 1,228 since last week. The Army figures are: killed, 91,625; wounded, 258,099; missing, 58,926; prisoners, 56,248. Navy: killed, 29,738; wounded, 33,469; missing, 9,427; prisoners, 4,486.

Approximately 11,000 seriously wounded men in need of special treatment have been flown back to the United States in fast ambulance planes since D-Day—more than 4,000 in the first month.

These giant flying hospitals, bigger than pre-war air liners, span the Atlantic in twenty-four to thirty hours. Each carries fifteen to twenty-five casualties, depending on the nature of their wounds. Over-all losses have been less than 2 per cent since D-Day.

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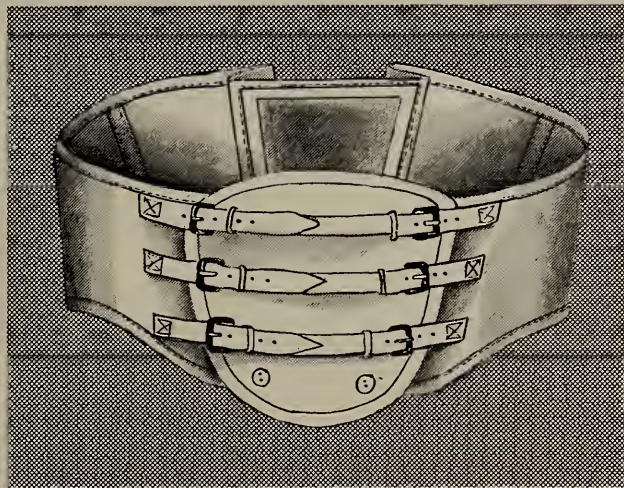
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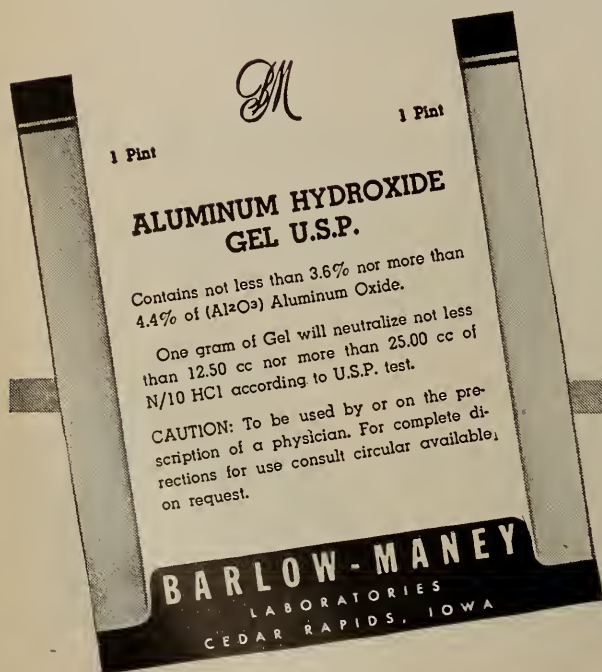
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The Pre-anesthetic Preparation of the Surgical Patient

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New York, N. Y.



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Anesthesia should be considered as the summation of the effects of premedication and the anesthetic agent proper. The selection of drugs for pre-anesthetic preparation, the amounts used and the time of administration are common sources for errors in the technique of anesthesia.

Pre-anesthetic medication has developed in a wide range from "an aspirin tablet" to "basal narcosis." A wide variety of drugs is in popular use. The rational of such therapy, the results desired and the consequences of its improper application to clinical surgery are discussed.

■ THE increasing pace at which new knowledge is being utilized to improve and extend surgical practices has provided anesthesiology with a challenge and at the same time an injunction to keep its practices in stride. The anesthetist's response, aided and abetted in no small measure by his confreres in the basic sciences and other clinical specialties, has been one of rapid improvement. For the most part, this has manifested itself in the acquisition of new drugs, improved appliances and entirely new procedures. The

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emphasis has been on the tools of the specialty and the efficiency of those handling the tools. The results in this direction have been encouraging. Much has been done to provide safer anesthesia for the patient. Now, and the time is opportune because the need is obvious, emphasis is being given to making the patient safe for anesthesia. In this endeavor attention is focused upon pre-anesthetic preparation. Pre-anesthetic preparation rather than pre-anesthetic medication because as the latter term is used usually, it refers to a drug given at a short interval before anesthesia is induced. Anesthesia should be considered as the summation of the effects of premedication and the anesthetic agent proper. But it is not enough to restrict the anesthetist's preparation of his patient to the premedication part of the procedure.

Pre-anesthetic Medication

It is no new practice to give drugs shortly before anesthesia is induced. Some twenty years after ether was demonstrated, Green recommended morphine injections during and immediately before inhalation anesthesia. Sixty-three years have passed since Crombi reported from India his experiences with premedication. At the turn of the century Korff was extolling "twilight sleep" before anesthesia, and twenty-five years ago Bordet was beginning the use of derivatives of barbituric acid.⁷ The modern concept, however, except as related to surgical preparation, has gained little significance. This tardy recognition has been the result of the empirical use of pre-anesthetic drugs and the convenience of routinizing practices. The time-honored "quarter and one hundred fiftieth" has become so firmly entrenched that it is almost traditional

in many clinics. The slightest reflection makes it obvious that the aforesaid dose of morphine and atropine to every adult who will be anesthetized is about as scientific as an ounce of castor oil for every one who is constipated. It is convenient to routinize hospital procedures and this is true especially if they are used more or less empirically. However, once a routine is established the incentive for improvement is suppressed. Although it is unwise to advocate hasty adoption of novel proposals or quick acceptance of the new, since both are equally as dangerous as rigid adherence to older methods, any anesthetic procedure that is routinized for an operation is potentially dangerous. It is not only the operation but the patient also that must be considered. Anesthetists should follow the lead of the modern surgeon who studies the patient with a disorder requiring surgical intervention rather than a surgical disease to be eradicated.

Errors in anesthesia, and there are many; unsatisfactory administrations, and these are not uncommon, result most often from faulty preparation. The knowledge, experience and judgment needed to complete the premedication in the total regime is not exceeded by that required to manipulate the procedure in the surgical amphitheatre. It does not suffice to excuse an unsatisfactory induction or maintenance of anesthesia for an improperly prepared patient by having a friendly surgeon say, "the patient took a poor anesthetic." The patient takes anesthesia in the manner in which it is given, poorly if given so, and poorly most often if he is improperly prepared for it. Nor is it permissible to jeopardize the patient by failing to protect against complications that may be anticipated or by increasing the hazards of complications already active by improper preparation.

The Purposes

Pre-anesthetic medication has for its primary purpose an increased margin of safety for the patient. His comfort and rapid convalescence are other important aims. The convenience of the surgeon and anesthetist are minor considerations. In the matter of safety it is pointed out usually that all anesthetic agents with the exception of nitrous oxide are protoplasmic poisons. In whatever way one may reduce the amount of these poisons needed, whether given by inhalation, by vein or by other methods, the pa-

tient's safety will be increased. It is established that patients who have received sedative drugs will require correspondingly less anesthetic agent depending upon the degree of narcosis already present. It does not follow, however, that the same dose of any hypnotic will produce the same degree of sedation in any two individuals of similar age and weight. This is not due to any great extent to an individual variation in drug effect but to the physical and emotional conditions of surgical patients.

The Rational

The thesis of Guedel is familiar wherein he correlates the reflex irritability or what might be termed resistance to anesthesia directly with oxygen demand or metabolic activity and indirectly with the state of mental activity.⁶ The oxygen requirements are increased in young people, those with fever and those with an increased metabolic rate from any cause. Such emotional disturbances as those associated with pain or fear add to the metabolic activity, and if suppressed, patients will require smaller amounts of anesthetic drugs to reach and maintain surgical anesthesia. Add to these the evaluation of the physical fitness of the individual, for example, contrasting the vigorous outdoor type with those of lassitude and slight muscular development, and the basis for choosing pre-anesthetic medication and the amounts needed is established.

In practice this tenet serves as a useful guide in the proper pre-anesthetic medication. To illustrate, patients with elevated metabolic rates, such as those with hyperthyroidism or infections, can be given properly a much larger amount of sedative drugs than is needed or is safe when there is a normal metabolic rate. Likewise for the old and young, a decreased amount of sedatives is imperative and can be approximated from Guedel's recommendations. However, such an evaluation of the patient is incomplete for adequate preparation with drugs. Other considerations are the anesthetic agents and techniques that will be employed later, the nature of the surgery to be completed, the postoperative requirements and of greatest importance, the nature of existing disturbed functions that may influence either the response to pre-anesthetic or anesthetic drugs. Simple illustrations are numerous. One would not argue for a vasopressor

drug before ether anesthesia because they are useful during spinal anesthesia. Nor would one presume that the same medication should be used when nitrous oxide is to follow that would be required when cyclopropane is chosen. The former agent is considerably less potent. Similarly, the different effects of the latter gas and ether are known well enough to recognize the need for variation in choosing pre-anesthetic drugs.

One could mention many operations that influence the use of sedatives. If a cranial exploration is proposed, an increase in intracranial pressure should not be produced with opiates. When shock is imminent one does not choose high spinal anesthesia.

An example of the postoperative needs is the patient with surgical diseases of the chest who should not have abdominal distention or a reduced cough reflex from hypnotics or opiates to interfere with pulmonary ventilation. Finally, disturbed physiological functions must be considered. Advanced hepatic insufficiency would contra-indicate avertin since it is conjugated in the liver with glycuronic acid. This discussion could continue with innumerable circumstances similar to those mentioned that need to be added as information in adopting the increased metabolism thesis to clinical pre-anesthetic medication. It may serve the purpose better to consider the more popular drugs in use and point out some of their limitations.

The Drugs

The opiates have a well-deserved place at the top of the list of drugs for use immediately before surgical anesthesia is induced. The morphine salts are representative and most widely employed. The profound analgesic effect of morphine is advanced to justify its use to control pre-anesthetic pain. It is readily agreed that such use is indicated but it should be remembered that there are other methods to control pain and secure comfort. Among these are nerve blocking, nursing care, freedom from worry and fear and other analgesic drugs. Their use should not be ignored in the relief of pain. Too much morphine before anesthesia may provide many difficulties for the anesthetist and many dangers for the patient. The decrease in respiratory minute volume exchange and the raised threshold for respiratory stimulation, both chemical and

nervous, if severe, may be a real hazard during and immediately after anesthesia. As an example of the difficulties for the anesthetist, could be cited the circumstances where it becomes more difficult to attain surgical anesthesia with ether because of too much morphine. Shallow, slow breathing and decreased sensitivity of the respiratory center to the irritant effects of ether prolong induction. If it is pushed, laryngeal spasm frequently follows and while spasm is present ether is absorbed by tissues, anesthesia becomes lighter and the process must be started again. Such inductions are often complicated by a prolonged excitement stage and copious secretions. Also with cyclopropane which is not stimulating, too liberal use of morphine causes respiratory depression and activates the asphyxial reflex stimulation of respiration (carotid body). When anesthesia is induced with a high concentration of oxygen, the reflex is obtunded and apnea results from further depression of the respiratory center by cyclopropane. The depression of the vasomotor center with large amounts of morphine may be a factor in circulatory collapse. The depression of the temperature-regulating center may favor heat retention or exhaustion. The decreased hepatic function and hyperglycemia, the constipating effect, stimulation of the vomiting center, increased intracranial pressure and many more side effects from morphine should be kept in mind when it is used for analgesia or premedication of the surgical patient.

Despite this disparaging discussion of morphine as representative of the opiates, it remains the most useful of all drugs for premedication. Useful, that is, if it will not be given injudiciously when its untoward effects would enhance an already disordered physiological function. Its great usefulness follows not only from its analgesic effect or that it is a cortical depressant, but from the favorable decrease in metabolic activity which reduces the requirements for complimentary anesthesia. To achieve this favorable effect, not only the dose, but the time and route of administration, assume importance. The objective and subjective depression with morphine does not parallel the analgesic action. When given subcutaneously, more than an hour will elapse before subjective narcosis attains its maximum. If it is given at a shorter interval before anesthesia is induced, its value is decreased

greatly, and often the anesthetist may realize that maximum effects are reached at a time when the patient is already deeply anesthetized and with a high concentration of anesthetic agent in his tissues. A dangerous overdose may be the outcome. When given intravenously, and it is altogether likely that this will soon be the rule, the desired effects are to be had in about ten minutes.

An analgesic recently added to those useful in premedication is marketed as demerol. Its action in therapeutic doses resembles that of morphine although the structural formula of the drugs are dissimilar. It has not been evaluated conclusively, but a recent comparative study in dogs and man concludes that it provides psychic sedation, facilitates induction, has fewer side effects such as nausea and vertigo and reduces the amount of complimentary anesthetic drug comparable to morphine. It does not depress respiration or other vital functions to the same degree as does morphine and it is more effective in drying secretions.⁸ More recently the impression is being established that one of its more favorable indications is in the preparation of elderly individuals.

Apomorphine in sub-emetic doses (1.5 to 2.0 mgs.) almost equals morphine in narcotic action. It is useful in combating delirium and has been of value for the patient addicted to alcohol.

It is common practice to combine with injections of morphine or demerol either atropine or scopolamine. Until recently these alkaloids of the belladonna plant were used primarily to depress salivary activity. This is an essential effect but by no means the primary one. Their action on the central nervous system as well as on smooth muscle is important. They counterbalance to some extent the respiratory depression caused by opiates and cyclopropane. Waters has shown that in the proper ratio with morphine, scopolamine produces an increase in minute volume respiratory exchange as contrasted with the same dose of morphine alone. The ratio was determined to be 25:1 and in the same amounts atropine was somewhat less effective.⁹ Moreover, the effects on blood pressure and pulse rate are less with scopolamine than atropine although the respiratory rate is increased more with the former. The effects on secretions are similar with both alkaloids but the subjective sense of dryness is greater with scopolamine. Burstein has

found that the onset of apnea was more rapid and the duration more prolonged when atropine or scopolamine was given with morphine.³ This is the result of paralyzing the chemo-receptors of the carotid body mechanism while the respiratory center was depressed, thereby preventing anoxic respiratory stimulation. The well-known psychic sedation of scopolamine which is not had with atropine greatly favors its use in premedication.

The most recent consideration given atropine and scopolamine in anesthesia is occasioned by their effect in modifying reflex activity of the autonomic nervous system. Attention is being directed toward reflex circulatory disturbances more frequently than in the past. The carotid sinus mechanism with hypotension and bradycardia; the vagovagal reflexes stimulated mechanically by manipulations in the thoracic cavity with cardiac inhibition, laryngospasm and apnea; the bronchospasms with lower respiratory tract obstruction are complications which may be avoided often with adequate amounts of the belladonna alkaloids. Particularly is this true when the barbiturates or cyclopropane are used since these drugs tend to increase parasympathetic activity.^{1,5} When drugs such as ether are used sympathetic activity is increased and reflexes such as the abdominal traction reflexes may be hyperactive. Such sympathetic influence is enhanced by atropine and scopolamine, a fact which must be taken into account when they are used before upper abdominal surgery.

Among the more popular group of drugs used before the induction of anesthesia are the derivatives of barbituric acid. These hypnotics have the specific action of reducing the toxic effects of the local anesthetics. This prophylactic action is of a nature to make it imperative that patients who will receive any but a very small amount of local anesthetic drug should not be denied the added safety afforded by a barbiturate. These drugs are used more often, however, for their sleep-producing qualities. It should be remembered that they are not analgesic and that therapeutic amounts usually increase the sensations of pain. As sleep provokers, they are given during the evening to "insure a good night's rest" before surgery and again shortly before anesthesia is induced to relieve apprehension. They are administered orally, by rectum and intra-

venously. Excepting when regional anesthesia is employed, they are more useful from the standpoint of the patient's comfort than his safety. Barbiturates are more difficult to use than the opiates, since there is a wide difference in the numerous derivatives available and the individual variation is more pronounced with this group of drugs than with most other therapeutic agents. The duration of action, fate in the body and toxicity must be known for each drug to use it properly. For example, in therapeutic doses barbitol is long acting and eliminated by the kidneys unchanged over several days. Amytal is intermediate in duration and is partly destroyed by the liver, partly eliminated unchanged, while pentothal is ultra-short acting and totally destroyed in the liver and other tissues. An example of improper use could be cited in the practice of giving by mouth a tablet of luminal (1.5 gr.) an hour before anesthesia is induced. It is a long-acting barbiturate, slowly absorbed, of low hypnotic potency and slowly eliminated. Such a dose would have slight hypnotic effect only hours after given.

The serious toxic effects of barbiturates are those of depressed functions but these are not pronounced with therapeutic doses. However, it may follow sometimes that in the anxiety to spare the patient any uncomfortable experience with surgery, these drugs are given too freely for safety. An illustration, the individual who may be a heavy smoker with a chronic pharyngitis and copious, tenacious secretions which collect during sleep, is given a barbiturate to insure sleep. The effects are not worn off in the morning when he is given more of the hypnotic and his cough reflex is depressed with morphine. Ordinarily he would cough and clear his respiratory tract of secretions before breakfast. Now he is anesthetized with all of them retained, the action of cilia is depressed, ventilation decreased and these secretions are aspirated to the lower respiratory tract. After operation more morphine, further depression, atelectasis and pneumonia may follow. Subsequently the complication may be listed as due to the principal anesthetic agent employed.

Paraldehyde has enjoyed the reputation of a safe hypnotic without serious toxic effects, that is rapidly eliminated by the lungs. Respirations are stimulated and human tolerance seems high.

Now there are accumulated data that impose extreme caution when paraldehyde is given intravenously since alveolar damage may follow with pulmonary hemorrhage and edema.⁴ When given by rectum or orally, the slower absorption reduces this threat but deaths have been reported, usually claimed to be due to idiosyncrasy, that cast suspicion on similar effects even with slow absorption.

Avertin in amylene hydrate has gained a merited popularity for use before complimentary anesthesia is induced. Given in aqueous solution by rectum, it is absorbed quickly (95 per cent in twenty-five minutes) and produces two effects unlike most other depressant drugs. Intracranial pressure and intraocular tensions are reduced. Its specific use where these effects are desired is obvious when there are no serious contraindications. Objections to its use are many but more particularly are associated with liver or kidney damage since the drug interferes with normal functioning of these organs. Some anesthetic agents containing halogen may produce acute yellow atrophy. Avertin has not been excluded from this list. It is an excellent hypnotic but effective for more hours than may be advisable for certain patients. It is tolerated well by the young and poorly by the aged. The doses now employed for adults in the range of 60 to 80 mg. per kilo body weight are more satisfactory than the larger doses formerly employed.

Other Pre-anesthetic Preparations

This discussion properly should include the role of many other drugs, foods, fluids and inhalation therapy in the pre-anesthetic preparation of patients. One might also include such important prophylactic procedures as the treatment of oral sepsis. These are more often discussed in reference to surgical preparation. Some common examples are insulin for the diabetic, iodine for the thyrotoxic, blood for the anemic and fluids for the dehydrated patients. Such preparation should be considered also in the role of prophylaxis for the complications of anesthesia. That such considerations are often overlooked is obvious when a few examples are mentioned. The body requirements for salt are exacting but normally may be supplied with less than the amount in one liter of normal saline. Anesthesia greatly reduces the salt tolerance. Yet normal

saline is used without considering these facts as a medium to give water before and during anesthesia. Vitamin C is depleted rapidly in patients during and after anesthesia. Animals deficient in this vitamin recover slowly or not at all from inhalation anesthesia that has little apparent after-effects on similar animals given adequate amounts of ascorbic acid before anesthesia.² The scope of this article will not permit more detailed discussion of these and similar factors in pre-anesthetic preparation but the future efforts toward safer anesthesia must include their serious consideration.

The Patient's Comfort

Another significant interest in pre-anesthetic preparation is the mental and physical comfort of the patient. Anesthetists have often viewed this phase of their practice with the ultimate goal of bringing the patient to the operating room and have him return without knowledge of the event. This is one reason for the popularity of rectal instillation on the ward. This may win the patient's favor but the whole question of his comfort in relation to anesthesia cannot be dismissed so easily. There has been growing the tendency to practice modern anesthesia with the new knowledge in the basic sciences, focusing attention upon laboratory techniques and neglecting the individual. The influence of emotional factors upon physiologic processes is better understood now but the specific effects these may have in determining the morbidity and mortality from anesthesia is still speculative. Some indications are suggested by the experience of the anesthetists in the war's combat zones. Patients include those of all ages and with all diseases. They afford more range for observation than in previous wars when casualties were predominantly well-conditioned young soldiers. The influence of fear, not alone fear of the outcome of impending surgery, but fear of strange surroundings, of strange people, of the fate of relatives, of death from bombs and all the other factors that enter into surgery at the front, is not completely evaluated. It is the impression that these individuals are unable to tolerate large amounts of the opiates, that they are depressed more easily with small amounts of anesthetic drugs and that vital functions such as respiration and circulation will withstand fewer insults. This is true also of the

soldier, young and physically conditioned. Similarly, fatigue reduces resistance to anesthesia and influences adversely the recovery from its effects. These circumstances are not those dealt with in times of peace or in institutions removed from combat except in isolated disasters. However, the implication is clear. Many patients fear the experience of being made unconscious, fear the effects from anesthesia more intently than the outcome of surgery. They submit to surgery for the benefits from such therapy but to them anesthesia is not a therapeutic procedure. It is a disagreeable, dangerous part of the affair. Too often patients have no idea of what the experience with anesthesia has in store for them or have only the stories of friends or accounts in the press to enlighten them. Similarly, too many have not the slightest idea who will serve as anesthetist. Excepting institutions caring for the indigent, they have a part in selecting the surgeon, and an opportunity to develop confidence in his ability and interest. The anesthetist is frequently selected by the surgeon but more often by the hospital. No statistics are available to assess the influence of such practices on morbidity or convalescence from anesthesia but it must be of some consequence. As one example, patients have developed syncope while being taken to the operating room, during spinal or regional anesthesia and at the time general anesthesia was started or as venipuncture was performed. Another is the incident early during induction, referred to often as hyperadrenalemia with sudden cardiac failure. Anesthetists with extensive experience remember it simply as the rare case that "was scared to death."

The pre-anesthetic visit of the anesthetist is an integral part of preparation. Such a visit is not made with the surgeon or internist to discuss the case or plan the procedure. That should be done elsewhere. The visit is made to become acquainted, gain confidence, learn the anesthetic history and to observe the patient in an environment other than the operating room. The surgeon can ably assist by giving the patient the assurance that anesthesia will be conducted by one with experience and skill. This is much more important than extolling the merits of a drug to be employed.

Finally, it should be pointed out that the significance of proper preparation of patients for

anesthesia is generally underemphasized. In the past, emphasis has been placed upon making anesthesia safe for the patient and too little attention given to making patients safe for anesthesia. It should be appreciated that no agent or method for anesthesia offers security for the patient not properly prepared. It must be realized that surgical patients are no longer satisfactorily grouped as clinical entities or types of diseases but that each is an individual requiring particular safeguards and preparation with the viewpoint not alone of existing pathology but of the patient as a whole. The routine use of any drugs for preparing patients for anesthesia is no longer accepted practice. Pre-anesthetic preparation must be rigidly individualized.

Summary

The role of pre-anesthetic preparation of the surgical patient is evaluated, its rationale presented and its practice outlined. The drugs in common use for pre-anesthetic medication are discussed. The anesthetist's role in such preparation is suggested.

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The Clinical Manifestations of Sulfonamide Toxicity and Hypersensitivity

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Because the literature on the sulfonamides has grown so rapidly it is difficult to keep abreast of the developments, a review of the clinical manifestations of the toxic effects is presented. These reactions to sulfonamides may be roughly classified into the following four groups: (1) The immediate toxic effects which are seen early in the course of therapy such as nausea, vomiting, headache, dizziness and diverse mental effects, as well as a direct nephrotoxic reaction with albuminuria and anuria; (2) The hypersensitivity reactions, which develop after several days of continued therapy or on the administration of a second course of the drug and are similar to serum sickness, including fever, dermatitis, conjunctivitis, arthralgias, prostration, delirium, urticaria, lymphadenopathy, bronchial asthma, jaundice and renal damage; (3) The disorders of the blood, many of which cannot be clearly classified at present either as hypersensitivity manifestations or the result of a direct toxic reaction; (4) The effect of precipitation of the drugs or acetyl forms on the urinary tract.

Special emphasis has been placed on the incidence and manifestations of the more common forms of the hypersensitivity reactions. Suggestions have been made concerning the time to look for toxic effects and the manner in which they may be avoided.

■ **THOUGH** sulfonamide drugs are of great therapeutic value the numerous reports of toxic effects resulting from the use of these compounds are evidence that the use of these drugs may at times be dangerous as well as life saving. The danger lies not only in the immediate toxic manifestations but also in the production of remote effects which may be even more serious. With the development of new compounds from the sulfanilamide base the immediate toxic reactions have been considerably decreased. Consequently, there is a greater tendency to regard the occasional untoward effect as of minor significance and to administer the drugs to patients in whom there may be only a remote possibility that such therapy will be helpful. Too little consideration is often given to the possibility of producing a sensitivity to the drug which may make the subsequent

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use of sulfonamide compounds dangerous or contraindicated when the patient is suffering from an infection for which sulfonamide therapy might be life saving.

Because the literature on the sulfonamides and on their toxic effects has grown so rapidly that it is difficult to keep abreast of the developments, a review of the clinical manifestations of the toxic effects is presented in this discussion. No attempt is made to describe the pathologic lesions found following the use of sulfonamides. Of particular interest in this regard, however, is the comprehensive review of the subject by Simon³⁹, the more recent reports of autopsies following deaths from sulfonamides^{3,12,19,27,28}, and the observations of Rich^{45,46}, on the role of hypersensitivity in periarteritis nodosa.

Incidence of Toxic Effects

It is difficult to evaluate the incidence of the toxic effects from the reports in the literature since this will vary with the type and the amount of the drug administered, with the duration of treatment, and with the repetition of treatment. Thus the number of cases exhibiting reactions after receiving sulfonamide therapy for two or three days will be considerably less than if therapy were continued for twenty or thirty days. Long²³, in a summary of the toxic effects of the commonly used sulfonamides given to several thousand patients in variable doses over variable periods in routine hospital management has found that toxic manifestations, as fever, rash, hemolytic anemia, leukopenia, agranulocytosis, hematuria, oliguria and hepatitis, occur in 11.9 per cent of the cases with sulfanilamide therapy, 15.9 per cent with sulfapyridine, 18.6 per cent with sulfathiazole, and 6.5 per cent with sulfadiazine. The experience with sulfamerazine or sulfamethazine is as yet insufficient to permit clear-cut conclusions concerning the incidence of toxicity of these drugs. The reports at the present time, however, would suggest that sulfamerazine has about the same toxicity as sulfadiazine.^{1,14}

The untoward reactions common to all sulfonamide compounds for the sake of simplicity may be roughly classified into three groups: a direct toxic effect which may manifest itself shortly after the drug has been administered; a state of hypersensitization or hypertoxicity which may appear after several days of continued therapy or after the readministration of the sulfonamide;

and the effects on the kidneys and urinary tract resulting from the precipitation of the drug or its acetylated form. Unfortunately, the information concerning some toxic manifestations is insufficient at present to permit such a classification. This is particularly true of the blood disorders that follow the use of the sulfonamides since some reactions might suggest a direct toxic effect while others with similar clinical characteristics would appear to be the result of a sensitivity.

Immediate or Direct Toxic Effects

The immediate toxic effects of the drug are usually quite mild but may vary in intensity and frequency with the dose and type of sulfonamide compound administered. All compounds in susceptible patients will produce nausea and vomiting presumably through a direct effect on the central nervous system. These symptoms were common with sulfanilamide and sulfapyridine but occur in only about 10 per cent of the cases treated with sulfathiazole, sulfadiazine and sulfamerazine. The other effects on the nervous system likewise are noted less commonly with the last three drugs than they were with the earlier compounds. Though headache, dizziness, lack of coordination, mental lapses and psychoses were not uncommon sequelæ in sulfanilamide and sulfapyridine therapy they occur so rarely with sulfathiazole or sulfadiazine that these drugs may be given in small doses to patients pursuing their usual daily routine. At times, however, serious disturbances will occur especially when administered in large doses or to patients with pre-existing disease of the nervous system. Dysmorphopsia, aphasia, agraphia, stammering, toxic psychosis, peripheral neuritis, encephalomyelitis, myelitis, optic neuritis, transitory myopia, meningeal signs, blindness and convulsions have been described as a result of sulfonamide therapy.²¹

Some reports suggest that sulfonamides may exert a direct nephrotoxic effect as well as produce kidney lesions from the precipitation of the drug. In such cases the evidence of renal involvement occurs early in the course of therapy and consists of heavy albuminuria, oliguria, anuria, and nitrogen retention. This is associated with microscopic evidence of tubular degeneration, glomerular swelling and occasionally widespread necrosis of the renal parenchyma.^{26,29}

Other untoward effects of the sulfonamides such as the disorders of the blood, hepatitis, or

the manifestations of a state of hypersensitivity to the drug may appear soon after the onset of treatment. Though in many instances they are immediate, toxic effects may not necessarily be the result of the direct effect of the drug itself and, therefore, are placed in a special group for later discussion.

Hypersensitivity Reactions

One of the most common and serious complications of sulfonamide therapy is the development of a state of hypersensitivity or hypertoxicity to the drug. These reactions are in many respects analogous to the clinical syndrome associated with serum sickness.²⁴ Like serum sickness the reaction is likely to develop during the second week. It may be manifest by the gradual or rapid development of many or all of the following effects: fever, chills, nausea and vomiting, skin eruption, conjunctivitis and episcleritis, muscle aches, arthralgias, profound prostration and transient delirium.^{13,25} Other manifestations such as albuminuria, oliguria, anuria, edema, urticaria, lymphadenopathy, splenomegaly, jaundice, bronchial asthma and leukemoid reactions have been noted on occasions in association with this type of reaction. The drug reaction differs from serum sickness in that no antibodies to the sulfonamides have been found by the usual methods. Efforts to demonstrate a sensitivity to the drug itself by means of skin tests or passive transfer have in general been unsuccessful.

It has been demonstrated that sulfonamides, especially sulfathiazole, may combine with plasma proteins.⁴ It would appear likely that in the body a combination between the serum proteins and the sulfonamides may be formed which acts as a foreign protein causing an immunological reaction similar to that associated with the injection of a foreign serum. Thus no antibodies would be formed to the drug itself but only to the combination of the serum protein and the drug. Wedum⁴⁵ was able to demonstrate sensitivity in guinea pigs given injections of sulfonamide azo-protein. Recently Leftwich²⁰ has described a method by which positive skin tests may be obtained in patients who have exhibited hypersensitive reactions to any of the sulfonamide drugs. The material used for skin testing consisted of serum obtained from patients who had received a sulfonamide for more than five days with a concentration of the drug in the serum greater than

2 mg. per 100 c.c. This test was found to be reliable in twenty-eight of thirty hypersensitive patients.

Since these hypersensitive reactions to the drug rarely occur before the sixth or seventh day and at times not until the third week of therapy, many patients receiving the sulfonamides for a shorter time will not experience such a reaction though sensitivity to the drug may develop. The incidence of these reactions is difficult to evaluate since it may vary with the duration and intensity of treatment and little attention has been paid to the minor manifestations such as malaise, muscle aches, conjunctivitis, etc. that develop several days after the onset of treatment. The incidence of the more dramatic episodes of a hypersensitivity reaction such as fever, chills, and dermatitis has been determined. In Long's large collection of cases, fever and dermatitis occurred with sulfanilamide therapy respectively in 5 per cent and 2.2 per cent of the cases; with sulfapyridine in 3.1 per cent and 2 per cent; with sulfathiazole in 6 per cent and 5.2 per cent, and in only 1.6 per cent and 1.3 per cent of the cases following the use of sulfadiazine.²³ It is probable that the incidence of these reactions would be considerably greater if the cases receiving large doses of the drug for seven days or longer were to be considered separately.²⁵

The clinical proof of a sensitivity to sulfonamides is the development of a hypersensitivity reaction to a second course of therapy. Several factors may influence the frequency with which such effects occur. The type of drug used, the dosage, the duration of treatment, the interval between the first and second administration and the dosage on the second administration of the drug are important considerations in evaluating the frequency with which a state of sensitivity may become manifest. In some instances the sensitivity may be transient while in other cases it may persist for several years.²⁰ Children may be less likely to develop sulfonamide sensitivity than adults.⁷

Reports concerning the incidence of sensitivity to the sulfonamides have varied widely probably because of the large number of factors affecting the manifestation of such a sensitivity. Lyons and Balberor²⁵ readministered 4 grams of sulfathiazole followed by 1 gram every four hours to fifty-three older adult patients two to fourteen days

after the completion of an asymptomatic short initial course of the drug. Nineteen of these patients (36 per cent) developed a fever and other manifestations of the hypersensitive reaction in an average of $13.2 \pm 13.2 \pm .4$ days after the initial exposure to the drug. Rantz³⁴ has estimated that 25 per cent of the patients receiving sulfathiazole may develop a sensitivity. From this it would appear that the readministration of sulfathiazole shortly after the completion of an initial course of the drug is associated with a considerable increase in frequency of the hypersensitivity reactions. This has recently been confirmed by Dowling and Lepper⁶ who found an increase in the incidence of drug fever on the second course of sulfathiazole, sulfadiazine and sulfapyridine. They noted reactions in 17 per cent of fifty-three cases receiving a second course of sulfathiazole and explained lower incidence of reactions from those above on the fact that half of their cases received only half doses of the drug with the second course. They noted a greater incidence of reactions when larger doses were readministered.

On the other hand quite different results have been reported in a group of fifty-five soldiers to whom sulfathiazole was readministered in variable doses. Only six of these cases developed any evidence of hypersensitivity.¹¹ The discrepancy in this report from the other observations may be due to the difference in dosage, the time the second course was given, and the age groups. It would appear likely that with a sufficient interval between courses sensitization to the drug may disappear in some patients. Nelson³⁰ is reported to have found that the readministration of sulfathiazole in routine hospital therapy was not associated with an increased incidence of reactions. It is also true that 20 to 25 per cent of the patients who have had a hypersensitive reaction to a second course may not develop a similar reaction with the administration of a third course.^{23,25} Fink and Wilson⁷ in a study of the incidence of these reactions in children on the readministration of sulfathiazole or sulfadiazine found that only seven of 177 cases so tested developed fever. The drug was repeated up to one and one-half years following the initial exposure and it is interesting that all of the cases having a reaction had finished the first course of the drug only one to six weeks before the development of fever with the second course.

Sulfathiazole appears to produce a greater incidence of sensitivity than the other sulfonamide compounds. This may be due to the fact that sulfathiazole is bound to the serum protein to a greater extent than other compounds.⁴ Dowling and Lepper⁶ noted only 7.4 per cent febrile reactions to the second administration of sulfadiazine in 68 cases and 9.1 per cent reactions to the second administration of sulfapyridine. Leftwich²⁰ found that 21 of the 30 hypersensitive patients he studied developed a positive skin reaction with sulfathiazole compared to four cases reacting to sulfapyridine, three to sulfadiazine, and four to sulfamerazine. Talbot and Adcock⁴³ in a study of the febrile reactions following a second administration of sulfadiazine found that fever developed in only three of thirty-four cases who had received the initial course without difficulty.

When a hypersensitivity reaction to a sulfonamide does occur the further readministration of the drug in the future is likely to reproduce the same reaction in about 75 per cent of the cases.^{23,25} In one case a febrile reaction was reproduced two years later.⁹ It is usually the rule that patients who develop a hypersensitive reaction to one compound may be able to take others without difficulty. It is not always true, however, for occasionally a state of hypersensitivity to many or all sulfonamide compounds may be produced.

Because of the frequency and severity of these reactions some of the more common manifestations of the hypersensitive state as the fever, dermatitis, changes in the central nervous system and kidney lesions will be discussed in more detail.

Fever

Drug fever, one of the more striking reactions to the sulfonamides, usually is seen during the second or third week of continued therapy if the patient has not previously been exposed to the drug. In some cases the fever is seen as early as the second day and in others not until the fifth or sixth week and occasionally it develops shortly after the discontinuation of therapy. It may start insidiously and gradually increase or come on abruptly with shaking chills and a rapid rise in temperature to 105-106 degrees. It is usually accompanied by other manifestations of the hypersensitive state particularly by profound prostra-

tion, joint and muscle pains, and at times delirium. In patients previously exposed to the sulfonamide compounds and who have developed a latent sensitivity, the readministration of large doses may precipitate an abrupt febrile response within a few hours. With cessation of sulfonamide therapy the fever subsides usually within forty-eight hours but at times some temperature elevation may persist for several days and the fever disappears by lysis.

Dermatitis

Skin rashes of many types have been noted following sulfonamide administration which, like fever, usually develop during the second or third weeks of therapy. Though skin changes are often associated with fever they may occur with other manifestations of hypersensitivity. The type of dermatitis varies considerably from patient to patient and depends to some extent on the type of sulfonamide compound used. An erythema nodosum or urticarial lesions are more commonly seen following the administration of sulfathiazole while a morbilliform or maculopapular type of reaction is more often seen with sulfadiazine.

The skin appears to be somewhat photosensitive and the eruption is more likely to appear following exposure to sunlight. In most cases the dermatitis will gradually subside when the sulfonamide therapy is stopped. The continued administration of the offending drug tends to increase the severity of the eruption and the other manifestations of the hypersensitivity reaction may then become more prominent. In some cases continued therapy has led to the development of serious and sometimes fatal exfoliative dermatitis. Readministration of the drug is likely to reproduce the skin eruption.

It is interesting that the local application of sulfathiazole ointments may be associated with sufficient absorption of the drug to produce not only a local cutaneous sensitization^{2,39,46} but also a general hypersensitivity reaction to the drug when it is administered orally.²² The cutaneous reaction may take the form of a local contact type of dermatitis with or without a disseminated eruption or it may appear as a local or generalized exacerbation of the dermatitis for which the patient is being treated.³⁹

The oral administration of sulfathiazole to patients who have used sulfathiazole ointment in the past has produced not only the manifestations of

a generalized hypersensitivity reaction including fever, chills, malaise, but also a dermatitis often localized to the areas previously exposed to the drug.²² Evidence of the cutaneous sensitivity can at times be obtained by patch tests. Somewhat similar reactions have been described in a patient sensitive to procain and other local anesthetics who developed erythematous pruritic edematous reactions at every site of previous application of a local anesthetic following the administration of sulfanilamide by mouth.¹¹

Nervous System

There is some evidence to suggest that the hypersensitivity reaction to sulfonamides may be associated with changes in the central nervous system. It is certainly true that delirium and a toxic psychosis frequently accompanies the febrile reaction. Little²¹ has ascribed other neurological manifestations such as peripheral neuritis to the intermittent administration of the drugs. Longcope has noted one case of coma and encephalitis following a hypersensitivity reaction.²⁴ Another case of encephalitis with associated renal changes proven by autopsy has been reported recently.²⁷

Renal Damage

Another serious manifestation of hypersensitivity is the development of albuminuria, oliguria and, at times, anuria shortly after the readministration of a sulfonamide.³² This may be associated with other manifestations such as fever, dermatitis or conjunctivitis. The fact that no crystals may be found in the urine even after catheterization of the ureters suggests that the suppression of urine must be in the kidney itself. The immediate cessation of sulfonamide therapy and supportive treatment may be associated with a return of kidney function as the other evidences of the hypersensitivity reaction disappears.

Differential Diagnosis

The differential diagnosis between the hypersensitivity reaction in its various forms and complications of the disease for which the patient is receiving sulfonamides may at times be difficult. In patients who have not previously received sulfonamides a sudden change in their clinical course after the sixth day of therapy should be viewed with suspicion. Usually more than one manifestation of hypersensitization may be pres-

ent or may develop in a few hours. The presence or absence of a leukocytosis may not be of aid. Though in the majority of patients these reactions are not associated with changes in the white blood cells some may show considerable change and at times a leukemoid response of the bone marrow may be present.

Blood Disorders

Blood disorders such as agranulocytosis, acute hemolytic anemia, and thrombocytopenic purpura are uncommon but exceedingly serious complications of sulfonamide therapy. Fortunately they are seen less often with sulfathiazole and sulfadiazine than with sulfapyridine or sulfanilamide therapy. It is not clear if these are the result of a hypersensitivity or if they are due to the direct toxic effect of the sulfonamides.

Acute hemolytic anemia, though rare, occurs early in the course of sulfonamide therapy and is usually seen during the third to fifth day of treatment.^{15,44} It is characterized by a rapid decrease in the erythrocytes, jaundice, urobilinuria, leukocytosis, reticulocytosis and at times in severe cases hemoglobinuria and uremia. It would seem that these reactions are an expression of an individual idiosyncrasy to the drug which in some cases may have been acquired through exposure to other compounds of a similar nature and in other cases may have rapidly developed during the sulfonamide therapy. This is suggested by the fact that readministration of the drug is often followed by a similar episode.

A more slowly developing anemia associated with hemolysis of erythrocytes is not infrequently seen with sulfanilamide and especially with sulfapyridine therapy but is rarely seen with the use of sulfathiazole or sulfadiazine. It is usually not an important complication of therapy since it is easily controlled by transfusions and is probably the result of a toxic effect on the bone marrow and red blood cells.

Thrombocytopenic purpura has been noted following sulfathiazole and sulfadiazine as well as with the use of the earlier sulfonamide compounds. Too few cases, however, have been studied to be certain if it is the result of a direct toxic effect on the bone marrow or a hypersensitivity reaction to the drug. In some of the cases reported the thrombocytopenia developed early in the course of sulfonamide therapy, on the second or third day, which might suggest a

direct toxic effect or an idiosyncrasy developed by previous exposure to related compounds. In other cases the purpura was seen after six or more days of therapy or with the readministration of the drug and it is possible that in these cases a sensitivity to the drug was developed during the course of therapy. Readministration of the drug following recovery from such a reaction may promptly precipitate another attack.^{17,38} Gorham et al.¹⁰ on the other hand, call attention to the similarity between the clinical signs of the hematotoxic action of benzol and aniline and those of the chemically related sulfonamide compounds. Kracke³¹ has shown that the platelet count tends to decrease on the first day of sulfathiazole therapy with a decided increase in the number of platelets on the first day after the drug was discontinued. This might suggest that the sulfonamides exert a primary toxic effect on the platelets.

In contrast to acute hemolytic anemia and thrombocytopenia, it is uncommon to see the development of leukopenia or agranulocytosis resulting from the administration of sulfonamides early in the course of therapy unless the patient has previously been exposed to sulfonamides. The decrease in the white blood cells is not usually encountered before the end of the second week and is more frequently seen between the fifteenth and twenty-fifth days of therapy. This reaction is seen especially with the use of sulfapyridine but is occasionally a complication of sulfathiazole and sulfadiazine therapy.¹⁶ In some cases it appears to be the result of a hypersensitivity reaction since readministration of small amounts of the drug will produce a rapid fall in the white count and granulocytes. In other cases, however, readministration is not attended by changes in the blood picture.²³ This is a particularly important point since it has been generally assumed that the agranulocytosis associated with sulfonamide therapy was the result of an idiosyncrasy. Since sulfonamides would be especially important in controlling the serious secondary infection associated with agranulocytosis, it is possible that they should be continued in spite of the agranulocytosis. Three cases of agranulocytosis that developed after sulfadiazine recovered completely with the prompt readministration of the drug and spontaneous regeneration of the granulocytes occurred during sulfadiazine therapy.³¹

Another type of leukopenia and agranulocy-

tosis has been described in rats and may have its clinical counterpart in man receiving sulfonamides over a considerable period of time. It was found that the administration of succinylsulfathiazole or sulfaguanidine to rats fed a purified diet produced a leukopenia and agranulocytosis which would respond to the administration of liver or liver extract.^{5,41} It is suggested that the sulfonamide compounds may produce this picture through a lowering of the intestinal synthesis of essential growth factors. It is possible that some of the cases of agranulocytosis noted in man following prolonged administration of sulfonamides may be the result of a disturbance in folic acid metabolism and the subsequent failure of maturation of white blood cells rather than a direct toxic effect or sensitivity effect. Under such conditions the favorable response to liver extract might be anticipated.

Liver Damage

Though sulfanilamide and to a lesser extent sulfapyridine have produced serious liver damage it is uncommon with the use of sulfathiazole and sulfadiazine. There is considerable evidence that sulfanilamide may exert a direct toxic effect on the liver early in the course of therapy. On the other hand, there are some cases in whom hepatitis developed in association with other manifestations of the hypersensitivity reaction. The problem has been well reviewed recently by Peterson et al.³³ in support of their belief that the presence of liver damage or jaundice does not contraindicate the use of sulfadiazine and its use may be indicated in cases of acute hepatitis associated with bacterial infections.

Urinary Precipitation

A common and usually avoidable complication of sulfonamide therapy is the precipitation of the compounds or their acetyl forms in the kidney tubules or ureters in sufficient amounts to produce mechanical obstruction to the flow of urine. Since these drugs and their acetyl forms are weak acids that are relatively insoluble in water or the normally acid urine, precipitation is likely to occur as the alkaline ions and water are reabsorbed from the glomerular filtrate in the tubules of the kidney producing a relatively high concentration of the drug in an acid environment. The amount of precipitation and the complications resulting

from it varies considerably with each of the compounds now in use depending upon the differences in the solubility of the free and acetyl forms and upon the rate of excretion of the drug. Sulfanilamide, the most soluble of all the compounds, is rarely associated with clinically significant precipitation. Sulfathiazole which is excreted very rapidly has only a small proportion of acetyl sulfathiazole in the urine but because of the rapid rate of excretion high concentrations of the drug occur in the urine with subsequent precipitation. On the other hand sulfapyridine and sulfadiazine are excreted more slowly and consequently have a greater proportion of the drug in the more insoluble acetyl form which favors greater precipitation. It is because of this that other compounds such as sulfamerazine or sulfamethazine have been developed which are slowly excreted and have an acetyl form that is more soluble.

It is not uncommon to find crystalluria in patients receiving sulfonamides. This is of little significance in most cases since crystals are likely to form as the urine cools from body temperature. On the other hand crystalluria in a warm freshly voided specimen is evidence that precipitation is occurring in the urinary tract although symptoms may not be produced. At times renal or ureteral pain, hematuria, burning on urination, or oliguria are the first indication of significant precipitation of crystals. This may go on to anuria with renal retention not only of nitrogenous products but also of the sulfonamides thereby causing acetylation to become more marked and thus predisposing to further precipitation and to the complete suppression of urine.

Fortunately these complications can usually be avoided. This is due to the fact that the solubility of these drugs and their acetyl forms may be greatly enhanced in an alkaline medium through formation of the soluble sodium salts. Thus a change in the pH of the urine from 6.5 to 7.5 may increase the solubility of sulfadiazine ten times.⁸ The solubility of free or acetyl sulfathiazole and sulfadiazine greatly increases as the pH of the solution is raised above seven so that it is of great importance to maintain an alkaline urine while these drugs are being administered. The maintenance of a large urine volume may also aid in the removal of the compounds without precipitation but is a relatively small factor in comparison to the alkalization of the urine.

Avoidance of Toxic Effects

Though the incidence of untoward complications with the sulfonamides is not high, especially with the use of sulfadiazine, deaths directly attributable to the drugs do occur. Sutliff, et al.⁴² estimated that in New York City there was one death in every 1,610 cases of pneumonia treated resulted from complications of sulfonamide therapy. Long²³ as estimated that 5,000 deaths per year result from the use of sulfonamides.

Fortunately, many deaths and severe sulfonamide reactions may be prevented by intelligent use of these drugs. Careful considerations must be given to the reasons for instituting sulfonamide therapy in a particular case and the drugs should be avoided in cases where there is only a remote possibility that such therapy might have a beneficial effect. Care should be taken to determine as far as possible the patient's previous experience with the drugs and the type of compounds previously administered.

Adequate supervision of the patient receiving the drugs will often prevent serious complications. This does not necessarily imply extensive laboratory procedures but does involve careful clinical observation and occasional laboratory tests. During the first few days the patient should be observed for toxic effects on the central nervous system. In patients who have received a course of sulfonamides in the past it is especially important to be alert during the first few hours of the readministration of the drug for the possibility of a hypersensitivity reaction, especially when large doses are administered. Early in the course of treatment the rare complications of an acute hemolytic anemia or thrombocytopenic purpura might be anticipated. The urine should be examined to reveal evidence of a direct nephrotoxic action of the drug and also to evaluate the presence of crystalluria.

Between the second and third weeks of therapy the hypersensitivity reaction is most likely to develop as well as the serious complication of agranulocytosis. White blood cell counts at this time are particularly indicated. Careful clinical observation of the patient may abort a hypersensitivity reaction before it becomes serious. The sudden development of malaise, arthralgias, conjunctivitis, skin rashes, or fever without other apparent cause should suggest such a reaction and immediate cessation of therapy may abort the

attack. Beyond the third week of therapy the possibility of the development of an agranulocytosis must always be kept in mind. At all times during sulfonamide therapy it should be remembered that the drug is being removed by the kidneys and that in an acid urine it is relatively insoluble so that crystals are apt to form. Since the solubility of the drug in its free or acetyl form is greatly enhanced by an alkaline urine the simultaneous administration of sodium or potassium bicarbonate is beneficial. The common practice of administering sodium bicarbonate in equal amounts with the sulfonamide will not necessarily insure an alkaline urine and it is often necessary to administer larger amounts of alkali. Frequent examinations of the urine to be certain it has an alkaline reaction, as well as a careful maintenance of an adequate urinary output, will be helpful in preventing mechanical obstruction of the urinary tract.

Summary

Some of the more common, toxic effects resulting from the use of sulfonamides have been discussed with particular reference to the time they are most likely to occur. The role of these drugs in producing a state of hypersensitivity analogous to a foreign protein reaction has been discussed. More careful clinical supervision of the patients receiving sulfonamides bearing in mind the possibilities of a toxic reaction may prevent unnecessarily severe or fatal complications.

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Advance in the Prevention and Treatment of Poliomyelitis

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Newly-acquired knowledge regarding the dissemination of the virus of poliomyelitis suggests no effective method for preventing its spread and makes our traditional public health procedures appear even more futile.

No inoculum has been invented which effectively increases resistance to the virus, although encouraging animal experiments have been carried out.

During the past few years discussions of treatment have been dominated by the Kenny physiotherapy technique. This method has been widely but uncritically accepted without even quantitative clinical observations, to say nothing of controlled clinical researches, having been carried out. It is unfortunate, particularly in dealing with poliomyelitis, that physicians and institutions could not have withstood the pressure for publicity until proper studies were made. Time-supported opinion seems progressively pessimistic regarding the results of the Kenny technique.

The theory behind the Kenny technique, developed apparently in retrospect after almost fetish-like details had been established, although physiologically and pathologically naïve has, however, stimulated many researches which will prove of great value.

■ I HAVE chosen to twist the title assigned to me to allow me to confine my discussion of this most interesting and complex disease to a consideration of the therapy of poliomyelitis in the light of the advances in our theoretical knowledge of the disease in the last few years. No research on my part justifies my assuming to address you on this subject, and I can only claim a great and constant interest as a close clinical observer of the disease.

I will start with a summary which may seem most pessimistic and depressing and quite lacking in matter for headlines. Although a great deal that is new has recently been learned which sooner or later will inevitably lead to our ability to control this dreaded disease, it seems to me that at present what we know makes us have less confidence in ourselves and feel less sure of being able to do anything to control the spread of

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the disease or influence its course than we felt five or ten years ago. During the last two decades, we have subjected our patients to a long series of therapeutic experiments ending in the Kenny treatment; therapeutic trials which have often caused pain and distress and always false hopes and great expense. All have been futile or nearly so except for adding to our experience. Many of the experiments should have seemed to us ill-advised at the time; all look so in retrospect. We have been driven by uncritical public opinion, urged to do almost anything to appease a frightened public. I do not think the medical profession can look back with much pride on these experiences unless it is pride in constant and versatile, though often uncritical effort. Nevertheless, we have gained a much more exact insight into the habits of the poliomyelitis virus and the pathogenesis of the disease it causes, an insight which should enable us to avoid more wisely in the future useless therapeutic gestures and which ultimately may lead us to the control of the disease.

I would like to review the subject therefore with a discussion of pathology, pathogenesis, immunology all mixed up with our efforts at treatment; to review past errors as a guide against present and future ones.

The first good observation of the pathology of poliomyelitis is I believe still the most important and needs re-emphasis at this time.

Some seventy years ago, at a time when little knowledge of the acute phase of poliomyelitis existed, Charcot observed the cords of victims of poliomyelitis who died months and years after the paralysis had occurred. He saw withered, shrunken cords which on histological section showed no other changes but a great reduction in the number of anterior horn cells in certain parts of the cord. Some years ago, we had the opportunity to examine the spinal cords of patients who died after living some months in a Drinker respirator with such severe and widespread paralysis that before the invention of that machine they would not have survived the acute phase of the disease. We saw such extensive destruction of the great motor cells that actual cavitation in the cord appeared, so that one could pass a probe up and down a tube-like cavity in the anterior horns.

Recently in the various attempts to rationalize the so-called Kenny treatment, belief has been

expressed that there is no true paralysis in poliomyelitis but that the resulting weakness was as I would express it a "pseudo-paralysis," due to some mental inhibitions or "alienation" derived from opposing tender muscles. I should like to emphasize the fact that the only pathological change that we know of that is permanent and that does not disappear after recovery from the acute stage of the disease is a loss of those anterior horn cells and we should tie to this and not be misled by physiological sophistries.

With better knowledge of the disease, the acute febrile illness that preceded or was associated with the paralysis was recognized and autopsies were done on patients dying during this stage. Many years ago, this acute pathology was beautifully described by Rissler of Sweden in a way that has not been improved upon. To summarize it very briefly, the picture in the acute stage consists of:

1. Changes in the great motor cells of the anterior horns showing different stages of a disease process varying from apparent partial degeneration to complete destruction.

2. Much more striking and extensive changes in the interstitial tissues of the cord and in the meninges. Throughout the cord, in the medulla, and sometimes in the brain itself there was evidence of acute inflammation with engorgement of blood vessels and collections of small round leukocytes in great concentration surrounding the engorged capillary vessels like dark collars. There were also less marked abnormal changes in nerve cells in the posterior horns, as well as in the brain.

For many years this inflammation and perivascular collection of white cells has been a subject of great controversy and has been the stimulus of many therapeutic ventures. Were the changes in the anterior horn motor cells primary and the other changes secondary and incidental, or was the disease in the anterior horn cells secondary to the acute interstitial inflammation? In attempts to analyze the progress of the disease, it was postulated by many that the anterior horn cells were destroyed by a local anoxemia brought about by choking off of their blood supply by the congested perivascular collection of white cells.

You probably all remember some of the attempts at therapy based on this hypothesis. Hypertonic solutions were given intravenously to

reduce the inflammatory edema of the cord and of the medulla. At the other extreme, hypotonic solutions were given combined with long continued spinal drainage. It was believed that these large dosages of parenteral water would increase the flow of spinal fluid and would actually wash away into the spinal fluid the lymphocytes that seemed to be obstructing the circulation in the capillaries. Adrenalin was injected into the cord and other efforts were made, all of which were supported not only by this theory but by reported excellent clinical results. Several methods seemed to different observers to work and were advocated with enthusiasm by their sponsors though we know now that the final results were not much different by one treatment than another and that no one offered in support of his arguments a control series of patients diagnosed the same way and as carefully observed but without the treatment.

There is now much evidence to convince us that the primary pathology is in the motor cells of the anterior horns and that all the other changes are secondary. Some very beautiful experimental work in monkeys has been carried out which I cannot take time to review in detail but which demonstrated that the virus first damaged the anterior horn cells and that the interstitial changes were secondary and did not occur in spite of inoculation with potent virus in sections of the brain or the cord where the large motor cells had been destroyed previously. All this makes us feel quite surely that these many attempts to increase the blood supply to the great motor cells were based upon a misconception of the pathogenesis and were quite futile.

Study of the pathology of the disease shows some few changes outside the central nervous system. There is definite evidence of disease in the lymphatic system, particularly manifest by engorgement in the Peyer's patches of the gut. These abnormalities, plus the evidence of meningeal inflammation, have seemed to some observers to indicate that the virus was first systemically distributed in the body and got to the central nervous system some way or other through the blood, lymphatic or spinal fluid channels. This seemed a very important conception and combined with observations regarding circulating blood immune bodies was the basis for other therapeutic experiments. It was long ago observed that the blood of men and monkeys con-

valescent from the disease contained antibodies. These antibodies can be demonstrated in one way only. When the serum of the convalescent animal is mixed with the virus (i. e., an emulsion of the cord of a victim of the disease) and this mixture incubated for a short time and then injected directly into a monkey's brain, the monkey remains well, while a control monkey injected with the same amount of the virus but without previous mixture with convalescent serum becomes ill with poliomyelitis. This experiment was repeated scores of times by many workers and established without a question the presence of some sort of circulating antibodies; with the demonstration of circulatory antibodies and with the assumption that the virus got to the central nervous system by way of the blood, lymphocytes and spinal fluid, it seemed logical that if convalescent serum containing these antibodies could be injected into the blood and spinal fluid of the victim early enough in the course of the disease it might block the progress of the virus to the central nervous system or prevent it from causing damage. Accordingly, in very extensive clinical experiments, many thousands of patients were given human convalescent serum intravenously and intraspinally in various dosages as soon as the disease could be diagnosed and before paralysis occurred.

A few years ago, in talking about this subject here on a platform with Miss Kenny as another speaker, I spent some time repeating the old story of this experiment with convalescent serum in an attempt to outline the possible error in other clinical experiments in human poliomyelitis. I must mention it again briefly, even though it is old history now, because this attempt to use convalescent serum seems to me almost a classic experiment in its perfect demonstration of a treacherous and common error in clinical experimentation; an error once again made in the evaluation of the Kenny treatment. In the first reports of the use of convalescent serums the results appeared excellent and the administration of this serum was enthusiastically carried out in spite of the tremendous labor involved. The patients given convalescent serum were painstakingly examined and the degree of their paralysis at different stages of their disease accurately recorded. Some hundred muscle groups in each patient were examined, and the degree of weakness quantitatively recorded so that a single fig-

ure could represent the total paralysis on a comparable basis for each of a large number of patients. The patients given convalescent serum showed far less paralysis than the control group with which they were compared, and the procedure was enthusiastically carried out for awhile without much question. It took several years, some thousands of patients, and very courageous and critical minds to detect the error in the experiment even though now it appears so obvious.

The patients given the serum were diagnosed in the pre-paralytic stage because of the concern of their families and the clinical acumen of their physicians, and were then treated. The control group not receiving serum with which they were compared were those not detected until after paralysis occurred when they were brought to a physician's attention because of their paralysis. Obviously the control group, therefore, did not include any of the patients with a non-paralytic form of the disease who also received no treatment because they escaped detection. When the experiment was repeated with serum given to only alternate patients discovered in the pre-paralytic stage by the same criteria, the comparable groups of these parallel series showed no important differences in paralysis.

Although the use of convalescent serum to produce a quick passive immunity has been discarded by clinicians very grudgingly, mostly for want of a substitute therapy, there exists therefore no good clinical evidence to justify it. Even the theoretical basis we now know was faulty because nobody can protect monkeys from poliomyelitis if the convalescent serum is not mixed with the virus before inoculation but is administered the way it must be given human patients.

The attempts to produce a temporary passive immunity having failed, an effort was made to produce active immunity by the injection of vaccines. Several rather extensive human experiments have been carried out using injections of attenuated or killed virus. So far, these have resulted in either simple failure or, in one instance at least, with evidence of rather disastrous results where a supposedly inactive virus may have caused paralysis.

Because of the present conception of immunity, work toward prevention of the disease by sera or vaccines is discouraging though the possibility of success is by no means exhausted. It is quite possible that the immunity that we can detect

in the form of circulating antibodies in convalescent serum has little to do with susceptibility or resistance to the disease. Experimentally in monkeys, at least, there seems evidence that only a local immunity is effective, that is an immunity in nerve cells that have already been attacked by the virus of poliomyelitis or possibly have been diseased by some other process. It is possible that poliomyelitis in one part of the central nervous system does not give a systemic general immunity but that another part of the central nervous system may still remain susceptible to an attack by a different pathology. This is apparently the case in monkeys and there are enough cases of two attacks of poliomyelitis in man to suggest that the conclusions from monkey experiments may apply also to the human subject.

I think it is well to point out the great difficulties in the practical use of any biological product for producing immunity even if an effective product were available. These difficulties are inherent in the low incidence of poliomyelitis and in its epidemic character. Since we have no way of identifying a susceptible or resistant individual, any procedure must be carried out on the entire population of a country or of an epidemic area. An average severe epidemic attacks 1 in 1,000 individuals. This is a figure for an epidemic area, not for the country at large. Of these, one in one thousand individuals, perhaps as many as one-fourth with a recognizable disease may get a severe and handicapping paralysis. Therefore, we may say that even if the procedure were limited to epidemic areas we must inoculate perhaps 4,000 individuals to prevent one having a serious paralysis. If we protect only children, the less susceptible adults taking their own risks, this figure would be reduced. If we should attempt such a procedure only in an epidemic area and not try to protect everybody in the country, then we would have to act fast to be effective. As it usually appears in a northern community, we have no good evidence that we are going to have a severe epidemic until well along in the month of July. Since it inevitably takes some time for organization and for the carrying out of our hypothetical procedure and since in most cases of active immunization at least some time must pass between an inoculation and a production of immunity, and since it is probable that infection of an individual has already taken place a week or two before the clinical

evidence of the disease, one can readily see the extreme difficulties in immunizing the community in a single epidemic before most of the victims have been infected. Any procedure which we may later develop must be so extraordinarily safe that the dangers of its application to thousands of individuals must be far less than the chance of one case of serious paralysis.

A great deal of new information has been collected about the way the virus actually gets to the central nervous system in man but up until recently the consensus was that the pathway was either through blood, lymph or spinal fluid as we have mentioned or was similar to that used to inoculate the experimental monkey. Monkeys were successfully inoculated by introduction of virus into their nostrils and the path of the virus through the monkeys' olfactory bulb down to the cord was fairly clear. If first there be injected some sclerosing agent such as zinc sulphate to cause scar tissues in a monkey's nasal mucosa, it was found that thereafter the monkey became resistant to a later intra-nasal inoculation. In the application of this monkey experiment to man it was proposed that the people in an area where poliomyelitis was epidemic be subjected to a similar prophylactic treatment of their nasal mucous membranes by a sclerosing substance to scarify the area and so prevent the passage of the virus to the individual if he should be exposed. Even at the time it seemed an ill-advised experiment to many if one properly considered the risk of cracks and fissures in a scar, the duration of a poliomyelitis epidemic, the low incidence of the disease, etc. However, the public heard of it, a popular medical writer described some preliminary reports with enthusiasm and so a rather extensive clinical experiment was carried out. Luckily for us our friends in Toronto did the work on a good experimental basis and on their own citizens and demonstrated the worthlessness of the procedure very quickly.

This was another example of the danger of trying to apply to man directly something learned by artificial experiments in animals. Since that experience more thorough study of the pathology in man with actual search for the living virus in victims of the disease makes it highly improbable that the virus usually enters the human body by the nasal olfactory nerve route.

Let me summarize now briefly, and therefore a little inaccurately, what I consider the best and

latest viewpoint as to the pathogenesis of the disease. It seems most probable that the virus of poliomyelitis goes to the central nervous system by moving along the axon of a peripheral nerve. How it gets to the body and how it makes first contact with a nerve ending is still highly conjectural. It does not get to the central nervous system through the blood, lymphatic system or spinal fluid. It passes through the axon of the nerve apparently causing no damage until it comes to a motor cell in the medulla or the anterior horn of the cord. There it attacks these cells which seem very specifically susceptible and it is probable that it attacks only healthy motor horn cells. A disease process is set up which may cause temporary disfunction or death of certain cells. Secondly, and dependent upon disease in these anterior horn cells, the inflammatory process in the interstitial tissue of the central nervous system occurs. We have no idea what determines whether a motor horn cell will be diseased enough to die, or to be temporarily functionless but recover, or to entirely escape, but we know that these possibilities exist. If this conception is correct the futility of many of our past efforts at treatment is apparent.

Now we come to a discussion of the Kenny phenomenon which is the latest attempt at therapy and of them all the most popularized by the lay press. It is indeed a phenomenon, and is of great interest in illustrating how we as a nation think and act as well as in its relation to this important disease. First, it demonstrates a commendable open-mindedness that physicians would seriously consider the claims of a nurse completely untrained in medicine or in basic science and from the time she first came to our country most contentious, intolerant of difference of opinion, and filled with a belligerent attitude towards the medical profession. Second, it illustrates what to me at least seems a very unfortunate lack of critical judgment in many physicians, a lack of knowledge of how to evaluate a therapeutic experiment, a lack of knowledge of the natural course of poliomyelitis and a reprehensible tendency, of which, however, physicians are not fully responsible, toward allowing premature publicity. It is hard to resist the fundamental American tendency to ride on the "band wagon," in medicine as in other fields.

This therapeutic venture differs from the others that I know of in that the theory or the ra-

tionale behind the technique followed its application and was developed as an afterthought to explain it. The history of Miss Kenny and her early attempts to cure this disease have been popularized so that I do not need to repeat the story. It is apparent that this very able, energetic, ingenious woman when of necessity left to herself in a difficult situation developed a procedure that seemed to result in the successful care of some patients who apparently suffered from poliomyelitis. Inevitably when she discussed it with doctors, they tried to explain it. These attempts at rationalization have gone on and on. I am not going to take the time to discuss them at length. As more and more inconsistencies appeared the arm chair philosophy to explain them has at times developed to a point of absurdity.

We may consider the Kenny treatment itself as consisting of two major parts:

1. Attempts to prevent pain in muscles with the local application of heat by a very specifically outlined procedure using hot, moist woolen blanket material.

2. The use of most skillful muscle training to re-educate the patient in the use of his affected muscles.

Neither of these procedures, as has often been stated by orthopedists in the past few years, is new in principle; only novel in the intensity of its application and in the fact that the muscle training is carried out earlier in the disease and immobilization used less than most physicians have recommended in the past.

Miss Kenny states that she is dealing with a new disease, one without true flaccid paralysis; that if she can carry out her treatment early enough there is no paralysis or deformity. She claims far less success in patients whom she sees late in the disease and who have been previously treated in what she calls the orthodox manner.

It is hard to summarize the rationale underlying this treatment though it has often been expressed by Miss Kenny and her disciples. Briefly, one conception which Miss Kenny has expressed is that the pathology lies in certain tender muscles, so painful to extension that the contraction of an opponent muscle is inhibited and therefore appears paralyzed though it is not truly paralyzed; therefore, attempts to diminish the pain and tenderness in the one muscle should make the apparent paralysis in the other muscle disappear. According to her concept, to take per-

haps the most absurd example, the pharyngeal muscles are inhibited in bulbar poliomyelitis by spasm and tenderness in the muscles of the neck which we have been accustomed to think of as useful to hold our head erect. Relief of muscle pain, therefore, constitutes a primary part of the treatment.

A second concept often expressed is that a victim of the disease forgets how to use a certain muscle, or as she expresses it, is mentally "alienated" from using it, apparently from pain or from what she calls "spasm." Re-education or muscle training constitutes therefore a second essential part of the treatment.

The attempts to construct a theoretical basis for the Kenny concept has directed a great deal of attention to this complex of pain, tenderness, or spasm in poliomyelitis. These symptoms have in turn led to a rather naïve rediscovery of the acute interstitial inflammation of the cord and later to a renewal of scrutiny of the acute changes in the other nerve cells than the motor cells of the cord. The questions that have arisen for solution are those related to the establishment of a theory to support the Kenny technique and others arising from renewed interest in muscle function.

Is there any basis for the conception that apparently paralyzed muscles are only inhibited or "alienated"?

Is there a relationship between tenderness, so-called spasm, and paralysis?

Is there evidence of a disturbance of the nicety of the reciprocal innervation of a muscle and its opponent that normally causes one to relax as the other contracts?

What is the nature of "spasm"?

Is the pain in poliomyelitis due to disease in the posterior horn cells or in the muscles, or both?

Does rest make any difference in the recovery of diseased anterior horn cells?

We must thank Miss Kenny for furnishing the stimulus for studies, which though so far leading to no very definite answers to our questions, cannot fail to increase our knowledge of muscle function.

From simple clinical observations, it is apparent that there is no good correlation between tenderness, paralysis or even the phenomenon which has been called muscle spasm. Some badly paralyzed patients have little pain and many with much pain have little paralysis. Since some of

the pain can certainly be alleviated by local heat to a muscle, it is evident that disease in the sensory cells of the cord can hardly explain it all. We are still very much confused as to whether the pain due to anterior flexion of the head and neck which is such a constant symptom is the same sort of pain as makes a muscle in an arm sore.

In an attempt to get more objective evidence regarding these points, recent research into this field has made great use of studies of the minute electrical impulses of healthy and partially paralyzed muscles. I must confess that I feel incompetent to do much more than report to you that such studies are being made. Definite answers to most of the questions posed have not yet been made clear, and the nature of the pain and so-called spasm in poliomyelitis is still obscure. Although the study of electro-myograms is still new, I believe one may make these statements:

1. There is no definite evidence of correlation between spasm and paralysis.

2. There are some abnormal electrical impulses arising from many muscles in cases of acute poliomyelitis, impulses which seem to be diminished by the local application of wet heat, but which are not limited to either the tender or spastic or paralyzed muscles.

3. There are other abnormal impulses from partially paralyzed and recovering muscles, but these do not seem to be specific for poliomyelitis, but may be found in other circumstances causing lower motor neurone paralysis.

4. There is evidence from electro-myography that there is indeed a disturbance in reciprocal innervation of the paralyzed muscle and its normal opponent, but we are not sure that this disturbance is specific for poliomyelitis.

The application of all this to treatment is still vague and while awaiting further study we might again recall that the only permanent pathological change that has been recognized in poliomyelitis is the destruction of anterior horn cells. There seems to be no evidence from electro-myography that local heat in muscles can influence paralysis. There is evidence from electro-myography that re-education of a patient in the use of his muscles can be of value, but certainly we have always been sure of this.

How can we evaluate the results of the Kenny treatment? Although this procedure has been

used in this country for a number of years with great interest and attention on the part of the medical profession, with the financial support of a great foundation and under the auspices of a medical school, there still exists no good data, no recorded quantitative observations of paralysis to say nothing of an alternate case controlled series than can afford us a certain basis for judgment.

I have outlined to you what steps were necessary to evaluate the serum treatment of poliomyelitis. In my opinion, no less cautious steps can be used to evaluate any other attempt at treatment of this disease that presents itself with such great and spontaneous variations in its course. However, we still have some basis for judgment as time itself gives us experience, though we must resort to unsupported personal opinions. We can ignore theory and only approach the problem as Miss Kenny herself does by looking at results, poorly recorded as they are.

I will refer you to the report in the *Journal of the American Medical Association* for June 17 of this year by the group of orthopedic physicians representing the various orthopedic societies of this country who made extensive investigations into the results of the Kenny treatment. They could find no evidence in support of the idea that the Kenny treatment was an improvement over the usual orthopedic procedures in the past. Why then should any one at any time by simply observing Miss Kenny's work be misled, if they were misled, into thinking that she was accomplishing miracles. In the first place, there seems to be an extensive ignorance on the part of many physicians as to the natural course of this disease. Reports are made giving specific figures as to the per cent of cures in fifty cases, in 100 cases, et cetera. Of course that is no proper way to evaluate results in this disease as there exists such great variation in the degrees of paralysis and in skills in detecting it. Let us go back to the data accumulated from the painful years of the serum treatment when careful quantitative muscle examinations were carried out, something Miss Kenny will not permit on her patients. This data probably represents the best approach to a quantitative estimation of the paralysis in the natural untreated disease. I will use very round figures because results differed somewhat according to different examiners and there is no justification for greater precision since

with increasing skill in early diagnosis more mild and non-paralytic cases are discovered. In general, out of 100 patients seen in the acute stage of the disease with all the usual clinical manifestations, fever, spinal fluid changes, muscle tenderness, stiffness in the back and neck, et cetera, some thirty will get no paralysis detectable by the most skilled and careful muscle examination. I would surmise that perhaps another thirty would have a paralysis too slight to be detected by the average physician. Of the remaining forty, possibly not more than twenty would have a serious degree of paralysis which would permanently handicap them. Of these 100 patients many but by no means all would have some muscle tenderness which would bear no constant relation to paralysis but which would necessitate the most skillful study to detect true paralysis. Practically all would have some tenderness or spasm of the neck and back muscles. Anyone with any experience at all in examining children, and most of these patients are children, knows that it is often impossible to tell whether a child who has soreness of muscle, bone or joint and appears paralyzed is crippled because he will not move or because he cannot move the painful limb.

It is very probable, I think, that the apparent paralysis or weakness seen during the acute stage of poliomyelitis is the sum of at least three different effects: permanent paralysis resulting from irreversible damage to anterior horn cells, temporary paralysis resulting from the temporary loss of function of "sick" anterior horn cells that can recover, a "pseudo-paralysis" resulting from pain or tenderness. That there occurs permanent destruction of motor nerve cells is unfortunately clear enough from pathological study. That the disease can temporarily cause lack of function in a motor cell that will later recover is less easily proved, but seems highly probable from study of the pathology in the monkey. How much of what I call the "pseudo-paralysis" of pain is just that and how much due to incoordinated nerve impulse caused by the acute inflammation in the cord remains to be established.

Therefore much of the initial paralysis in this disease spontaneously disappears, and Miss Kenny and her followers have fallen into the same error of claiming credit for this as their ultimate "cures," as we have done before in many

therapeutic trials in this disease. But what about the other cases treated by Miss Kenny and her workers long after the acute stages of the disease? She has seemed to make a long paralyzed muscle move in a way that has impressed all observers. It seems to me very unfortunate that her great skill in what we have long called muscle training has been overshadowed by the unfortunate overemphasis on her treatment in the acute stage and on all the hot packs with their fetish-like application that has been so impressive. Miss Kenny herself claims her best results in the acute stage of the disease and thinks she accomplishes less when she sees her patient later after some physician has treated him. One can well believe that the reverse is true and that she has been misled by her lack of knowledge of the natural course of the untreated disease and that she helps the most in the later stages by her boldness and skill particularly with patients not too well treated previously by physicians.

I think Miss Kenny has done an immense amount of good in spite of some possible harm. Many of us have too long and too completely immobilized partially paralyzed muscles or those we thought paralyzed in the acute stage of the disease and have allowed an atrophy of disuse to occur and have not tried energetically enough to teach our patients to use what muscles they have after very long disuse, either from pain as Miss Kenny emphasizes, or from immobilization. We must definitely acknowledge that the trust we have had in certain time-honored orthopedic principles, such as the importance of long rest of weakened muscles, rests on almost as poor a basis of clinical studies with controlled observations as does Miss Kenny's treatment.

The effect of the personal magnetism or whatever it is that sets apart the healer in the history of all races from others without this dynamic personality, is something that I find quite impossible to evaluate. I wish I had it. But we do not need to resort to mysticism to understand the frequent excellent results of Miss Kenney's personal attention to a victim of poliomyelitis.

I think that epidemics of these last two years have made it very clear that again our people have suffered great disappointment in a treatment at first highly praised. We should look back with criticism of ourselves as physicians for not having demanded that any experimental thera-

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The New Year

To our many members in Michigan and those scattered throughout the world, our sincere wish is that the year 1945 will bring them a fullness of health, prosperity and happiness. Although our membership is now in every nation on the globe, let us hope and pray that we may be reunited in 1945.

May the New Year bring to us all, first, the end of the global conflict; second, the unity of our people at home; third, the restoration of our many brothers to their normal pursuits, and finally but most important, the wisdom in our leaders to bring about the successful establishment of permanent peace.

A. S. Brunk

President, Michigan State Medical Society

President's



Page



Editorial

VERNOR M. MOORE, M.D.

■ Vernor M. Moore, M.D., President-Elect of the Michigan State Medical Society, died at his home in Grand Rapids, Saturday, December 30, 1944. The shock of this untimely death leaves us appalled. Dr. Moore attended the Executive Committee of the Council meeting at Detroit, December 14, and appeared in the best of health and spirits, planning his coming administration of the Society and his year of increased service to his beloved profession.



Dr. Moore, as a member of the Council and in the deliberations of the administrative group of the Society, will be sorely missed. He always responded when his advice was needed; his thinking was clear and went through to the ultimate goal.

In the eighty years of our society's existence one other president has died before assuming office. In 1892 Charles J. Lundy, M.D., of Detroit, died before taking office and his Vice President, Gilbert V. Chamberlain, M.D., of Flint, presided.

THIS IS 1945

■ A new Year and a new series of problems are upon us. The past year has witnessed some progress and some heartaches. We lay the past away with mixed feelings of regret for what we failed to accomplish and of satisfaction in measures of real progress that have been taken. The war is progressing satisfactorily, and we begin to see faintly hopes of some of our medical men coming back to take their rightful places in our midst. It has been another year with great labors and great accomplishments in giving medical and surgical care to the civilian population, and to industry, while such a large percentage of our effective members are "away to the wars." The work has been done, and without too much waiting or neglect for the people who were suffering. The Doctors of Medicine have readjusted to their increased duties, and have been able to

carry the increased loads with a little more efficiency, and a little less personal strain. They have delivered the goods, without fanfare, and in a most satisfactory manner.

And our members wearing the uniforms of the armed forces. Theirs has been a year of most successful accomplishment. The armies are at death grips, and the casualties are reaching proportions that command attention. Our men who were our confreres and co-workers so short a time ago have shown the world that they are supermen. The work done for the wounded and sick in the far parts of the world has been nothing less than miraculous, and these men whom we considered as good as, and no better than we ourselves have done that tremendous work. The American medical man when given a herculean job to do DOES IT.

We wish all our doctors, abroad or at home, in uniform or out of uniform, the most successful New Year—may its problems bring joy in the solving and contentment in the results.

POLITICAL MEDICINE

■ Do you wish to have someone, a layman, standing at your back and telling you when you can practice medicine, what patients and how many you may care for, what remedies you may prescribe?

Do you wish to be told whether you can practice medicine as a general practitioner, a surgeon, an obstetrician or a neurologist? Do you wish to be assigned to a locality, and told you must practice there?

NO, that is un-American and cannot happen to us in these United States, you say.

Don't be too sure.

Earl Godwin in his broadcast* just recently called attention to the increased tendency in Washington bureaucracies to regiment medicine. He mentioned the fact that several bills are now in Congress, chief among them being the Wagner-Murray-Dingell affair, to bring about government control of medical practice. He warned

*Friday, December 1, 1944.

that renewed efforts will be made in the new congress to further this program. That bill promises services to millions that cannot now be rendered in some parts of the country without relocating members of the profession, and reassigning to them duties that they do not now have.

In Michigan the threat is even closer at home. The proposed amendment to the Constitution of the State will promise to every "normal citizen" complete medical, surgical, obstetrical, dental, pharmaceutical, nursing and hospital care, without charge, and as his right. We know there are not enough practitioners in any one of these fields to give this service as it will be demanded if and when the new plan goes into effect.

The Amendment sets up a Director of Social Insurance who will administer the department, and "shall make such arrangements as it deems advisable with licensed physicians, dentists, and with nonprofit voluntary hospitals, municipal hospitals, county hospitals, state hospitals and university hospitals in order to be able to furnish the medical, dental and hospital benefits contemplated by the amendment." Nonprofit and government hospitals are to be the only ones used. Private hospitals will be out of business.

The political campaign is over and the visionaries who have spotlighted the drive to federalize medicine have been returned to office with what they call a landslide. Is it to be expected that they will be any the less insistent on their program? The pressure for federalization will be even more forceful. The counteracting of this wave of socializing is the business of EVERY MEMBER of the medical profession unless the questions like those above are to be answered in the affirmative.

The only way to influence people is to tell them your views. There cannot be too many contacts with the men who must do the voting to put this program into effect. They are YOUR Congressmen, and are supposed to do *your* will. *Start your important contacts TODAY.*

Michigan's Contribution

During the year just passed Michigan has offered two contributions to the war against political medicine. We have placed Michigan Medical Service on a sound financial basis. We have

proved that plans offered and operated by the profession can be successful, and that we have something to offer that meets the needs proposed to be covered by government interference. Studies are in progress to determine the terms under which we can offer increased benefits. One person out of every eight in the state is covered by Michigan Medical service certificates, and one out of every five is covered by Michigan Hospital Service, in which fact the profession can take its full share of pride. These two plans are the result of Michigan's efforts, and our profession had its full share in their progress.

During the year just passed we have established the Michigan Health Council and taken a public opinion survey which shows the sentiment in Michigan much more favorable than the famous *Fortune Magazine* survey, or the California State Medical Society survey. Results of this survey have been published in the November JOURNAL, and comments appear in our editorial pages. We solicit constructive comments from our members, now that they have had an opportunity to read the reports. Lessons have been pointed out and suggestions made to correct some of the unfavorable opinions expressed in the report. Every member should study this survey with his own interests at heart, and should make whatever adjustments he may determine should be made. There is no reason that the public opinion of our profession should not be 99.44 per cent perfect.

The Michigan State Medical Society recently completed a series of five-minute radio dramas over a network covering the entire state, setting forth incidents encountered in the life of a doctor and how he helps in the building of health and happiness in our people. It was the work of professional radio dramatists and writers, produced by a well-known advertising agency. This was in furtherance of the direction of the House of Delegates of the Michigan State Medical Society in promoting good public relations.

We are not too keen on New Year's resolutions—they are too fleeting. As a society we have kept the faith. As individuals we have also kept our efforts in the right direction. May the whole profession continue to give of their very best to the promotion of good health of our people. Such service from each of us will stay political medicine. It thrives where there is dissatisfaction, and only there.

A NATION-WIDE HEALTH PROGRAM

■ A release has come from the office of Dr. Michael M. Davis, chairman, "Committee on Research in Medical Economics," we quote:

"Concerned with *how to distribute the best kind of medical care* to the people of this country, a group of physicians joined forces a year ago with a group of economists and administrators, whose main purpose was *how to pay for this care*. Working together as a Health Program Conference, they have formulated a new nation-wide health program. It differs significantly from other such proposals in bringing together the medical and financial aims. Moreover the plan represents the joint and unanimous conclusions of 29 men and women of widely varying interests. Thirteen of the conference members are physicians, some in private practice, others from universities, health agencies or hospital administration."

"A basic condition of the plan is the protection of the physician in his right to accept or reject patients and to take part or not in a publicly established system." "The plan assures patients the right to choose their own doctors and hospitals. It also safeguards existing hospitals, clinics and voluntary health insurance plans which meet acceptable standards, in their right to supply services and to take part in the system." "The conference proposes comprehensive services."

"In order that comprehensive service shall be available to all, or most, of the population and in order to minimize the administrative costs of acquiring members it is essential that financial participation in the system be required by law."

"The national health program should include general tax funds from the start, especially to aid (a) new or improved hospitals and health centers, particularly in rural areas, (b) the further extension of full-time health departments and other preventive measures, so that every part of the country will be served thereby, and (c) the provision or improvement of medical services to those dependent and other persons not directly covered by the insurance systems."

"Group medical practice is to be encouraged." "Hospitals should come to function as medical service centers, offering preventive, diagnostic and treatment services for bed, ambulatory and home patients and providing office facilities for the physicians on their staffs."

"The principles would permit fees for service, but would tend to encourage the compensation of general practitioners by the capitation or salary method."

This report is a 36-page booklet and fails to say who appointed the Committee on Research in Medical Economics. It states that "thirteen are physicians, some in private practice." A study of the list shows four are members of the "Committee of Physicians for the Improvement of Medical Care" which came into prominence by self-appointment some time ago to speak for the profession in adverse criticism of the profession

during the time of the Supreme Court hearings. Three are Federal government employees, two are hospital administrators, one represents a great Foundation, one is director of "Medical Administration Service," and one, who could be in private practice, is chairman, Physician's Forum. This does not sound like a true or just representation of the medical profession. Of the sixteen other members of this Committee ten are government officials and four are members of the Board of the American Association for Social Security. Two represent Labor, five are professors of Economics. Some of these hold two classifications.

This plan or system as they call it is about as desirable in the administration of medical care to the public as is the Wagner-Murray-Dingell atrocity. The lengths to which those long-haired dreamers and star gazers will go to socialize and regiment medicine is just dawning upon us.

To remove the taste of this splurge from your mouth read the fine Editorial in the *Saturday Evening Post* for December 9, 1944. To quote:

"If anything like the Murray-Wagner-Dingell Social Security Bill passes doctors will become state job holders with no more personal interest in your tonsils than could be expected of the clerk of bills at the city hall."

"Your family doctor, who is wearing himself out by his efforts to spread medical care as far as he can, thinks that his number is up. Right or wrong this is what most doctors think, and if you doubt it, the thing to do is ask your doctor."

"We are approaching a day when physicians will be merely a class of skilled laborers, readily hired and fired by their community medical centers."

"The patients never wanted state medicine anyway, but only some sort of prepayment scheme which would make it possible for a man of modest income to pay his own medical bills. Actually the doctors want this too. They welcome patients who carry health insurance and many of them encourage and participate in group insurance and group medical plans."

ADVANCE IN THE PREVENTION AND TREATMENT OF POLIOMYELITIS

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peutic attempt be properly recorded and quantitated and that proper control cases be chosen for comparison, and also with some humility that the challenge of this nurse has been necessary to stimulate long-needed research in muscle function and a fresh evaluation of our own entrenched orthopedic habits by more critical clinical studies.

MICHIGAN STATE MEDICAL SOCIETY

Seventy-ninth Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

Pantlind Hotel, Grand Rapids, Michigan

(Continued from December issue)

X. Constitutional Amendments Presented in 1943

Referred to that Committee are those matters on amendments to the constitution that were presented last year and referred to this year's House of Delegates. You will find them on page 18, 19, 20 and 21 of your Handbook.

Article III, Sec. 4—Associate Member for Physicians in Service

Article III, Sec. 4—Memberships for Physicians Temporarily Retired

Article III, Sec. 8—Life Membership

Article VIII, Sec. 2—Succession of President-Elect

Article VII, Sec. 4—Membership for Physicians Temporarily Retired.

Are there other resolutions?

C. E. SIMPSON, M.D. (Wayne): Mr. Speaker, the Council of the Wayne County Medical Society wishes the House of Delegates to make changes in the membership affecting two of our older members. It comes in the form of these two brief resolutions from the Wayne County Society:

VIII—2. SPECIAL MEMBERSHIPS (EMERITUS-RETIRED)

Resolution No. 8 was presented by C. E. Simpson, M.D., of Wayne.

WHEREAS, Emil Amberg, M.D., of Detroit, is an honor member of the Wayne County Medical Society and has engaged in the active practice of medicine for fifty years, and

WHEREAS, Dr. Amberg has been a member of the Michigan State Medical Society in good standing for well over the twenty-five years as prescribed in the By-laws, and

WHEREAS, Dr. Amberg has maintained an ethical practice and contributed greatly to the welfare of the public and the advancement of the profession, particularly as a distinguished leader for the Detroit League for the Hard of Hearing, and

WHEREAS, The Council of the Wayne County Medical Society recommends that he be favorably considered for Emeritus Membership in the Michigan State Medical Society; therefore be it

RESOLVED, that Emil Amberg, M.D., of Detroit, Michigan, be elected by this House of Delegates to Emeritus Membership in the Michigan State Medical Society.

Resolution No. 9 was presented by C. E. Simpson, M.D., of Wayne.

WHEREAS, George M. Livingston, M.D., of Detroit, Michigan, has retired from the acting practice of medicine, and

WHEREAS, Dr. Livingston was born in 1867, was graduated from the University of Michigan in 1898, and has long served the community and his medical societies with skill and dignity, and

WHEREAS, The Council of the Wayne County Medical Society has accredited Dr. Livingston with special membership recognition; therefore be it

RESOLVED, that the name of George M. Livingston, M.D., of Detroit, Michigan, be placed on the list of retired members of the Michigan State Medical Society.

THE SPEAKER: Thank you. These resolutions will be referred to the Reference Committee on Resolutions. Are there further resolutions?

F. H. DRUMMOND, M.D. (Bay): I have four resolutions I would like to present at this time:

Resolution No. 10 was presented by F. H. Drummond, M.D., of Bay.

WHEREAS, E. C. Warren, M.D., Bay City, has practiced medicine since 1900, and

WHEREAS, Dr. Warren has been a member of the Bay County Medical Society and the Michigan State Medical Society since 1917, and

WHEREAS, Dr. Warren has been accorded Emeritus Membership by the Bay County Medical Society, therefore

BE IT RESOLVED, that Dr. E. C. Warren be accorded Emeritus Membership by the Michigan State Medical Society.

Resolution No. 11 was presented by F. H. Drummond, M.D., of Bay.

WHEREAS, V. L. Tupper, M.D., Bay City, Michigan, has been in practice since 1896, and

WHEREAS, he has been a member of the Michigan State Medical Society since 1906, and

WHEREAS, he has retired from the practice of medicine, and

WHEREAS, the Bay County Medical Society has accorded Dr. Tupper "Retired Membership," therefore,

BE IT RESOLVED, that the Michigan State Medical Society concur in according Retired Membership to Dr. V. L. Tupper.

Resolution No. 12 was presented by F. H. Drummond, M.D., of Bay.

WHEREAS, William Kerr, M.D., Bay City, has practiced medicine over 50 years, and

WHEREAS, Doctor Kerr has been a member of the Bay County Medical Society and the Michigan State Medical Society over 25 years, and

WHEREAS, Dr. Kerr has been accorded Emeritus Membership by the Bay County Medical Society, therefore

BE IT RESOLVED, that Doctor William Kerr be accorded Emeritus Membership by the Michigan State Medical Society.

Resolution No. 13 was presented by F. H. Drummond, M.D., of Bay.

WHEREAS, V. L. Tupper, M.D., Bay City, has fulfilled all the requirements for affiliate fellowship in the American Medical Association.

BE IT RESOLVED, that the Michigan State Medical Society recommend to the American Medical Association that Dr. V. L. Tupper be awarded an Affiliate Fellowship in the American Medical Association.

THE SPEAKER: Thank you, Dr. Drummond. These will be referred to the Reference Committee on Resolutions.

H. F. Dibble, M.D. (Wayne): Mr. Speaker, I have one resolution to present.

VIII-3. STUDY OF MEDICAL PRACTICE PROCEDURES IN NEBRASKA, CALIFORNIA AND NEW JERSEY

Resolution No. 14 was presented by H. F. Dibble, M.D., of Wayne.

WHEREAS, it appears that many osteopaths are prescribing drugs and practicing therapeutics in violation of Act 162 of the Public Acts of 1903, and

WHEREAS, such violations of the laws of the State of Michigan are detrimental to the *public health and welfare*, therefore be it

RESOLVED, that when the present emergency ceases, steps be taken to clarify the *status* of osteopaths, particularly in regard to the practice of therapeutics, and

BE IT FURTHER RESOLVED, that as the preliminary step, the *judicial decision* of the Supreme Court of Nebraska defining the limits of osteopathy, and the action of the State medical societies of California and New Jersey toward absorbing the Osteopaths, be studied.

THE SPEAKER: Thank you, Dr. Dibble. This will be referred to the Reference Committee on Resolutions and as a little bait to get you all here at ten o'clock tomorrow morning, one of the first we have will be a brief talk by M. C. Smith, the Executive Secretary of Nebraska, who will talk on this particular problem. Are there further resolutions?

R. H. PINO, M.D. (Wayne): I think it is a good thing not to mix up the resolutions that come from any one county or any other place. It happens I didn't know about the resolution Dr. Dibble just presented and in coming up this afternoon, this subject came under a great deal of discussion and another method of attack was suggested so we have a resolution on that point. Now, this can be taken into consideration by the Resolutions Committee and added or detracted. We are not in disagreement in the matter.

VIII-4. QUALIFICATIONS OF PRACTITIONERS OF DRUG THERAPY

Resolution No. 15 was presented by R. H. Pino, M.D., of Wayne.

WHEREAS, all comprehensive practice of the healing art by individuals who profess to use medicine and surgery includes the use of chemicals, drugs and biologicals which if not skillfully administered may become dangerous to individuals and the public health,

BE IT RESOLVED, that any practitioner or group of practitioners of the healing art who use such chemicals, drugs or biologicals must pass a common Board of Examiners named by the State and acceptable to the Department of Medical Therapeutics of the universities of Michigan.

BE IT FURTHER RESOLVED, that the Michigan State Medical Society through its Council and Legislative Committee give consideration to the promotion of such legislation.

Resolution No. 15a was presented by R. H. Pino, M.D., of Wayne.

WHEREAS, a recent Selective Service ruling provides that there shall be no deferments for pre-medical and medical students not enrolled in medical schools by July 1, 1944;

WHEREAS, this ruling will reduce entering classes in 1945 by about 30 per cent thus drastically curtailing medical classes;

WHEREAS, many such pre-medical and medical students would necessarily be physically disqualified men or women;

WHEREAS, it is obvious that the number qualified would be entirely inadequate to meet the needs of medical care in this country during the next decade;

WHEREAS, many young medical officers will be detained in the Army and Navy and Air Corps for some time following the war thus adding to the deficit;

WHEREAS, appeal to the Army and Navy and President of the United States by the AMA have been unproductive of results; be it therefore,

RESOLVED, that an appeal be made directly to the members of Congress from Michigan by the Michigan State Medical Society urging these members of Congress to take cognizance of a situation that inevitably will reduce the numbers of Doctors of Medicine in the United States to the point where medical care will be reduced far below necessary standards required to maintain safety of health care not alone from the standpoint of contagion but in all other aspects of health.

BE IT FURTHER RESOLVED, that the office of the Society implement this resolution.

THE SPEAKER: Thank you, Dr. Pino. You will have ample opportunity to discuss it tomorrow and you have the right and you are invited to go to the Resolutions Committee.

Any further resolutions?

VIII-2. SPECIAL MEMBERSHIP

Resolution No. 16 was presented by John J. Walch, M.D., of the Delta-Schoolcraft Medical Society.

WHEREAS, Dr. Nancy Rodger Chenoweth has been a member of the Delta-Schoolcraft County and the Michigan State Medical Societies for thirty-two years and has practiced medicine for fifty years, be it

RESOLVED, that she should be given Emeritus Membership in the Michigan State Medical Society.

THE SPEAKER: This will be referred to the Committee on Resolutions.

Resolution No. 17 was presented by J. J. O'Meara, M.D., of Jackson.

At a meeting of the Jackson County Medical Society on May 24, 1944, the following motion was presented and carried. It was moved by J. J. O'Meara, M.D., and seconded by C. S. Clark, M.D., that the Jackson County Medical Society hereby instruct its delegate to the 1944 House of Delegates of the Michigan State Medical Society to present the name of William W. Lathrop, M.D., of Jackson to said House of Delegates for Member Emeritus; motion carried.

THE SPEAKER: This resolution will be referred to the Committee on Resolutions. Are there further resolutions?

Resolution No. 18 was presented by L. C. Harvie, M.D., of Saginaw.

WHEREAS, Dr. Arthur Grigg is a member in good standing of the Saginaw County Medical Society and the Michigan State Medical Society and has been in practice for fifty years, therefore,

BE IT RESOLVED, that the House of Delegates award him an Emeritus Membership.

THE SPEAKER: This will be referred to the Committee on Resolutions.

VIII-5. COMMENDATION OF MMS ADMINISTRATION

Resolution No. 19 was presented by G. L. McClellan, M.D., of Wayne.

WHEREAS, Michigan Medical Service has provided the means whereby several hundred thousand people of this state have been able to secure medical care on a prepaid budgeted basis, and whereas this medical care has been rendered in a manner which has been generally highly satisfactory to both patient and physician, and whereas this has resulted in better feeling and understanding between the public and the medical profession, and

WHEREAS, the present management of Michigan Medical Service has made a splendid record in financially rehabilitating the corporation and in harmonizing differences,

BE IT RESOLVED, that we, the members of the House of Delegates of the Michigan State Medical Society in meeting assembled this 25th day of September, 1944, wholeheartedly commend the chairman, and its officers and directors of Michigan Medical Service for their splendid achievement, and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the AMA and to each County Society and a suitable copy to each officer and member of the Board of Directors of Michigan Medical Service.

THE SPEAKER: This will be referred to the Committee on Medical Service.

VIII-2. SPECIAL MEMBERSHIPS

Resolutions No. 20, 20A and 21 were presented by A. T. Hafford, M.D., of Calhoun.

WHEREAS, Dr. J. Holes has been a member in good standing of the Calhoun County Medical Society for over forty years and has retired from active practice,

BE IT RESOLVED that he be elected to retired membership in the Michigan State Medical Society.

WHEREAS, Dr. Paul Roth has been a member in good standing of the Calhoun County Medical Society for over forty years and has retired from active practice,

BE IT RESOLVED that he be elected to retired membership in the Michigan State Medical Society.

WHEREAS, Dr. Bertha Moshier has been a member in good standing of the Calhoun County Medical Society for over forty years and has retired from active practice,

BE IT RESOLVED, that she be elected to retired membership in the Michigan State Medical Society.

THE SPEAKER: These will also be referred to the Resolutions Committee.

VIII-6. RECOMMENDING VARIOUS STUDIES TO MICHIGAN MEDICAL SERVICE

Resolution No. 22 was presented by S. W. Insley, M.D., of Wayne.

WHEREAS, the Michigan State Medical Society has always been in the vanguard of leadership in matters pertaining to public health responsibilities and,

WHEREAS, the Michigan State Medical Society was the original sponsor of Michigan Medical Service some years back and,

WHEREAS, Michigan Medical Service has by this date demonstrated its physical and financial soundness in its present scope of activities, therefore,

BE IT RESOLVED, that the Michigan State Medical Society now request the Michigan Medical Service to make appropriate studies with the ultimate aim of further improving its usefulness by integrating the numerous health services now being offered by various public and semi-public agencies.

THE SPEAKER: That also goes to the Committee on Resolutions.

VIII-7. CONDENSING HOUSE OF DELEGATES PROCEEDINGS

Resolution No. 23 was presented by T. K. Gruber, M.D., of Wayne.

WHEREAS, a complete stenographic report of every resolution, motion, and word spoken during the Annual Session of the House of Delegates of the Michigan State Medical Society is transcribed and retained in the permanent archives of the Society, available for study by any member of the State Society at any time; and

WHEREAS, a national need exists for saving vital paper stock such as is used in THE JOURNAL of the Michigan State Medical Society; and

WHEREAS, The Council of the Michigan State Medical Society recommends that the considerable expense of publishing every word as spoken before the MSMS House of Delegates in THE JOURNAL be curtailed at this time, if possible; therefore,

BE IT RESOLVED, that the House of Delegates instruct The Council to condense the annual transactions of the House of Delegates as published in THE JOURNAL of the Michigan State Medical Society.

THE SPEAKER: This resolution will be referred to the Committee on Reports of Councils.

VIII-8. ASSESSMENT FOR PUBLIC EDUCATION

Resolution No. 24 was presented by Henry Cook, M.D., of Genesee.

WHEREAS, it appears that the public has not been sufficiently informed as to the serious results of certain movements to change the system of medical care, nor of the deterioration in medical service that will result if such movements materialize,

RESOLVED, that the membership of the Michigan State Medical Society be assessed \$10.00 per capita for educational purposes.

THE SPEAKER: Thank you, Dr. Cook. This will go to the Resolutions Committee.

VIII-2. SPECIAL MEMBERSHIPS

Resolution No. 25 was presented by D. J. O'Brien, M.D., of Lapeer.

At a meeting of the Lapeer County Medical Society on August 29, 1944, the following motion was presented and carried. It was moved by Dr. H. B. Zemmer, seconded by C. G. Bishop, M.D., that the Lapeer County Medical Society hereby instruct its Delegate to the 1944 House of Delegates of the Michigan State Medical Society to present the name of Henry G. Merz, M.D., of Lapeer, to said House of Delegates for Member Emeritus; motion carried.

Resolution No. 26 was presented by D. J. O'Brien, M.D., of Lapeer.

At a meeting of the Lapeer County Medical Society on August 29, 1944, the following motion was presented and carried. It was moved by Dr. H. B. Zemmer, seconded by C. G. Bishop, M.D., that the Lapeer County Medical Society hereby instruct its Delegate to the 1944 House of Delegates of the Michigan State Medical Society to present the name of David H. Burley, M.D., of Alma, to said House of Delegates for Member Emeritus; motion carried.

THE SPEAKER: Thank you, Dr. O'Brien. They will go to the Committee on Resolutions.

VIII-9. ENDORSING CENTENARY OF NITROUS OXIDE ANESTHESIA

Resolution No. 27 was presented by R. J. Armstrong, M.D., of Kalamazoo.

WHEREAS, 1944 marks the centenary of the application of a practical method of anesthesia by nitrous oxide, therefore be it

RESOLVED, that the House of Delegates of the Michigan State Medical Society commend and endorse the celebration during 1944 of the centenary of this application of nitrous oxide anesthesia.

THE SPEAKER: This will go to the Committee on Resolutions.

VIII-10. RE: EMIC PROGRAM

Resolution No. 28 was presented by L. W. Day, M.D., of Hillsdale.

WHEREAS, the EMIC program was referred to The Council for study, and

WHEREAS, a special committee of The Council was assigned to the task, and

WHEREAS, after many meetings and conferences were held with representatives of the Children's Bureau, health authorities, specialist groups, general practitioners, hospitals and other interested groups, and

WHEREAS, as a result these alternatives were presented by The Council to the profession namely:

(1) Sign the blanks to provide for hospital service, giving professional care gratis; or

(2) Sign the blanks and accept the government fee for medical care; or

(3) Decline to participate in the program, as physicians see fit.

BE IT RESOLVED, that this action of The Council be approved.

THE SPEAKER: Thank you, Dr. Day. That will go to the Committee on Resolutions.

VIII-13. SELECTIVE SERVICE FOR MEDICAL STUDENTS

VIII-2. SPECIAL MEMBERSHIPS

Resolution No. 29 was presented by Alfred LaBine, M.D., of Houghton County.

At a meeting of the Houghton-Baraga-Keweenaw County Medical Society on May 2, 1944, the following motion was presented and carried. It was moved that the Houghton-Baraga-Keweenaw County Medical Society instruct its delegate to the 1944 House of Delegates of the Michigan State Medical Society to present the name of W. T. S. Gregg, M.D., of Calumet, to said House of Delegates for Member Emeritus; motion carried.

Resolution No. 30 was presented by Alfred LaBine, M.D., of Houghton County.

At a meeting of the Houghton-Baraga-Keweenaw County Medical Society on May 2, 1944, the following motion was presented and carried. It was moved that the Houghton-Baraga-Keweenaw County Medical Society instruct its delegate of the 1944 House of Delegates of the Michigan State Medical Society to present the name of G. F. Brewington, M.D., of Mohawk to said House of Delegates for Member Emeritus; motion carried.

THE SPEAKER: These will go to the Committee on Resolutions. Are there further resolutions? (none)

XI. Reports of Standing Committees

THE SPEAKER: We will go next then, to the Reports of Standing Committees. You will find them listed in order on page 10.

XI-1. LEGISLATIVE COMMITTEE

The Legislative Committee report is printed on page 51 of the Handbook.

The Legislative Committee report will be referred to the Reference Committee on Standing Committees.

XI-2. COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

Next is the Committee on Distribution of Medical Care. That report is printed on page 61. Is there a supplemental report? It is referred to the Committee on Standing Committees.

XI-3. REPORT OF REPRESENTATIVES TO JOINT COMMITTEE ON HEALTH EDUCATION

Report of the Representatives to Joint Committee on Health Education is printed on page 58. Is there a supplemental report? If not, it is referred to the Committee on Standing Committees.

XI-4. MEDICAL-LEGAL COMMITTEE

The Committee on Medical-legal Committee report is printed on page 79. Is there a supplemental report? It will be referred to the Committee on Standing Committees.

XI-5. PREVENTIVE MEDICINE COMMITTEE

The Preventive Medicine Committee report is published on page 58. Is there a supplemental report? This also will go to the Committee on Standing Committees. There is a general report by the chairman and then there are all these subcommittees and each one submits a separate report. If there are no supplemental reports on any of these, we will just read them through:

- XI-6. Cancer
- XI-7. Maternal Health
- XI-8. Venereal Disease Control
- XI-9. Tuberculosis Control
- XI-10. Industrial Health
- XI-11. Mental Hygiene
- XI-12. Child Welfare
- XI-13. Iodized Salt
- XI-14. Heart and Degenerative Diseases.

All of these subcommittee reports will be referred to the Reference Committee on Standing Committees.

XI-15. POSTGRADUATE MEDICAL EDUCATION

The Committee on Postgraduate Medical Education. Is there a supplemental report. It will be referred as printed on page 53.

XI-16. PUBLIC RELATIONS

The Committee on Public Relations? Referred as printed on page 72.

XI-17. ETHICS

The Committee on Ethics? That will be referred as printed on page 28.

XII. Reports of Special Committees

Next come the Reports of Special Committees.

XII-1. NURSES' TRAINING SCHOOLS

The Committee on Nurses' Training Schools, as printed on page 51, is referred to the Reference Committee on Special Committees.

XII-2. COM. ON PRELICENSURE MEDICAL EDUCATION

The Conference Committee on Prelicensure Medical Education. That will be referred as printed on page 60.

XII-3. RADIO COMMITTEE

The Radio Committee. Referred as printed on page 61.

XII-4. ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

The Advisory Committee to Woman's Auxiliary. Referred as printed on page 29.

DR. REEDER: As chairman of that committee, I haven't any further written report, but if proper, I would like to say just a word.

DR. REEDER: This Committee of course, consists of three of us who are widely scattered, so therefore, there were no meetings held. However, as Chairman of this Committee, I have taken it upon myself for the past two years to really take an active part, by way of correspondence as well as personal communications with the officers of the Women's Auxiliary. I have found, and I know that you have felt perhaps in the past that the women didn't mean much to us, but I have heard it given little consideration and I want you to know that the Woman's Auxiliary of the Michigan State Medical Society is one of the finest assets we have. They are really getting down to work. They have done some splendid work and their work, particularly in the past two years, should really be commended by this House. It is really marvelous.

The activity they have aroused and the reading they do, I dare say the officers and the committees of the Woman's Auxiliary are reading a great deal more of your MICHIGAN MEDICAL JOURNAL than most of our male members are. They are following the headlines of the newspapers. They are extremely interested in politics and the old saying, "The way to win a man's heart for a woman is to fill his stomach," is not true any more, but she is certainly helping to win over the politicians.

Therefore, I think it behooves us to give the Woman's Auxiliary more consideration, and particularly, I would ask the Council to help them financially when necessary and let us turn in and help them.

THE SPEAKER: Thank you.

XII-5. PROFESSIONAL LIAISON COMMITTEE

The Professional Liaison Committee. There is no report in the Handbook. Is there anyone on that committee who wishes to report? No report.

XII-6. BEAUMONT MEMORIAL COMMITTEE

The Beaumont Memorial Committee. The report is printed on page 50. It will be referred to the Reference Committee on Special Committees.

XII-7. COMMITTEE ON PROCUREMENT AND ASSIGNMENT OF M.D.'s

Committee on Procurement and Assignment of M.D.'s. There are two printed reports by this committee. There is the report of the committee and a supplemental report on pages 76 and 77. If there are no additions, the reports will be referred to the Committee on Standing Committees.

XII-8. JOINT COMMITTEE WITH THE STATE BAR

Report of the Joint Committee with State Bar of Michigan is printed on page 66. Is there a supplement? If not, it will be referred to the Committee on Special Committees.

Now, I would like to make two or three announcements. First, we will meet promptly at ten o'clock after we have our motion to adjourn. As we announced before, tomorrow morning M. C. Smith will speak to us on the problem in Nebraska.

The other announcement is the places of meeting of the reference committees. You will find them on the blackboard. They will meet in ten minutes and if you do not know your chairman, go to that room and he will meet you there.

(The Speaker read the rooms in which committees were to meet.)

THE SPEAKER: I would like to ask, as a special favor, to these delegates here, that those reports all be in by tomorrow morning at ten o'clock insofar as that is physically possible. Probably the Resolutions Committee won't be able to get theirs in by that time because they have a tremendous amount of work to do, but the rest of you, please have your reports ready then.

There are two other things I would like to say. Once

more, the stenographers are in the back of this room. Dr. Foster makes a request that you get your work to the stenographers as early as you can.

A motion to adjourn is in order and we will meet promptly at ten tomorrow morning.

(Upon motion duly made and seconded, it was voted to adjourn until ten o'clock Tuesday morning.)

(The meeting recessed at twenty minutes past eleven o'clock.)

Tuesday Morning Session

September 26, 1944

The meeting convened at ten minutes past ten o'clock with The Speaker presiding.

THE SPEAKER: The House will please come to order. Is the Credentials Chairman ready to report?

J. J. O'MEARA, M.D.: Mr. Speaker: I hold here the credentials of the accredited delegates to the Michigan State Medical Society, of which 50 per cent are not from any one county.

THE SPEAKER: If there are no objections from the House, the Credentials Committee Report will be accepted as the roll call for this meeting.

It is a pleasure this morning to call upon an important individual in medical circles from our sister state of Nebraska, M. C. Smith, Executive Secretary of the Nebraska State Medical Society, who will speak to us on their problem of the osteopath. Mr. Smith.

VII-3. ADDRESS OF M. C. SMITH, NEBRASKA

Already, this morning, I am learning something about Michigan hospitality, and I assure you I am getting to like it.

I am very happy to bring to you officially, the greetings of a sister organization, the Nebraska State Medical Association, whose problems after all, are very much your problems and very much the same.

I have been asked to tell you, in a period of approximately ten minutes, how Nebraska solved its osteopathic problem. I am sure you can see immediately that that will be quite a task, because osteopathy has been a problem ever since the morning of June 22, 1874, at ten o'clock in the morning, when Dr. A. T. Spell received a vision, apparently from on high, whereupon he established the so-called profession of osteopathy.

I can only tell you very briefly what has taken place in Nebraska. Our legal status, as exemplified in our laws, is very similar to yours. In fact, before 1939, you had a better law than Nebraska. You have had some rather bad deals from your Attorney General; interpretations which have given you a situation which brought you down to our level at that time.

In 1941, in our session of the legislature, the osteopaths brought a bill, as a result of the Supreme Court decision in Nebraska, which stated very definitely the activities that osteopaths might pursue in Nebraska, in which they said osteopathic surgery was merely manipulating surgery. They gave us a definite definition of osteopathy, after considerable research, that I am sure is going to stand for a long time to come, and I hope it will help you in your problems.

A bill was presented at that session of our legislature asking that the osteopaths in Nebraska be permitted to practice medicine and surgery on exactly the same basis as a medical man. We were able to defeat that bill, but only by a small margin of three votes. We were advised by members of the legislature that, at the next session, the 1943 session, it would be advisable for us to bring something before the legislature which was constructive rather than continuing attempts to be obstructive in our legislative activities.

Our Committee on Medical Economics started to work

shortly after the close of the 1941 session and they spent two years preparing our bill which was LB-139, and I am sure at least some of you are familiar with it.

Our committee started from the ground that if a man is qualified to practice medicine and surgery, he should be permitted to practice medicine and surgery regardless of the school from which he was graduated. Perhaps that is just a little revolutionary thinking, but our committee worked from that basis.

We have had the difficulty, and I am sure you have had the same difficulty, of too many men of this sub-standard group, who as soon as they received their D. O. degrees, represented themselves to the public and to their patients, as medical doctors. Frequently we meet the statements, as I know you have met them, that they were even better than medical doctors because they had everything a medical school could give them, and in addition, they were osteopaths. We have met that frequently, and therefore, as a part of our bill there was a clause placed therein which stated that every practitioner of the healing art in the State of Nebraska must have at his office, at each entrance to his office, a sign in letters no less than one inch high, giving his name, his degree, if any, and immediately under his name, osteopath, chiropractor, or optometrist. They must place the letters in equal height, showing their particular practice or school from which they graduated.

In other words, most of the medical men in Nebraska had to change their signs where they merely had "Dr. John C. Jones." Our medical men were forced to change their signs to read "John C. Jones, M.D." An osteopath must give his name, "John Doe, D.O.," and then "Osteopath." No longer would the people be taken to an office and given the impression or the idea that they were consulting a medical doctor. If they went to the man's office, they knew they were consulting an osteopath.

We also inserted a registration clause requiring every practitioner of the healing art to register in the county of his practice. We made that quite detailed. He had to give his date of graduation. A special book was provided for each county in the state showing exactly the man's education; when he graduated, the type of education, and also the degree which he held, so that no longer could any individual, not only an osteopath, but any individual, represent himself for something which he was not, because this is a matter of public record and any individual could go to the county courthouse and find that man's history. There is a story behind that provision in our law, but I won't take the time to tell you about it.

Probably the most important feature of our bill, as it is now operating, is the fact that we have set up a new type of registration and educational qualifications. Our examining board now approves the medical schools from which students may be examined in Nebraska. We have run into a little difficulty on that particular point and we are very sorry about it, but it was impossible for us to accept the AMA approval of medical schools and not accept the same thing from the osteopathic schools.

Now, a school, in order that its students may be permitted to take an examination from the Medical Board of Nebraska, must meet certain basic standards as set up by our examining board. Our examining board, therefore, has set qualifications, and in the law, it may not change these qualifications for any particular type of school. The same basic qualifications must apply to all schools. On that basis, then, an osteopathic school that is able to meet the basic standards and basic qualifications of medical education may send its students to Nebraska where they may take the medical examinations, and they are successful in passing, they will receive the same license as a medical doctor receives. That is a little revolutionary.

Also, our State Board of Examiners has been increased from three members to five, which we think is much better. At the present time, we now have the

best medical examining board Nebraska has ever had, and the board assures us that any individual who is able to pass that examination is qualified to practice medicine.

By virtue of the fact that they have a license to practice osteopathy, we have permitted those osteopaths who are now practicing in the state to take the examinations if they make application to the Board prior to July 1, 1948. As a surprising result, at our last examination in December of last year, there were twenty-one osteopaths who took the examination. Of that group, six passed the examination. One man passed with a grade of 83, which is very good. Our board feels that that man should be permitted to practice medicine and surgery in Nebraska, and he now holds such a license. Some of the other men failed miserably.

Our case started from a man who was an osteopath doing surgery in the western part of Nebraska. That particular man in the examinations where one osteopath received a grade of 83, got an average grade of 47. His grade in operative surgery was 27. He, of course, has been weeded out.

At the present time, our situation is such that the osteopaths now in practice may take the examinations, and if they are qualified, they will be permitted to receive a license exactly the same as a medical man. The new men coming in may take the Basic Science Board examination. We still have that. They may take their Osteopathic Board examination if they wish to practice osteopathy.

Our supreme court has definitely defined osteopathy. There is a part of our law which states that a license may be revoked for any practitioner of the healing art who invades another field of that practice. If an osteopath does surgery, he is brought before the examining board, and is not only charged with practicing medicine while being an osteopath, but loses his license.

I wish I had more time to discuss with you the various features of our bill, but I know you are very busy as delegates. I am going to talk to the secretaries tomorrow night and I expect to give a rather brief discussion of how we got into our difficulties and how we got out and how we got our bill passed in the legislature.

THE SPEAKER: Our next order of business is unfinished business.

VIII-11. ENLARGING MMS BENEFITS

Resolution No. 31 was presented by C. F. DeVries, M.D., of Ingham.

WHEREAS, requests have been made of Michigan Medical Service to study various phases of services now provided, and

WHEREAS, the present bed shortage in the hospitals in the various communities of the State is of so serious a nature as to endanger the public health, be it

RESOLVED, that Michigan Medical Service be hereby requested to study ways and means of providing for the performance of minor surgery in the physician's office.

THE SPEAKER: Thank you. This resolution will be referred to the Resolutions Committee.

Is there other unfinished business?

VII-4. REMARKS RE: TECHNICAL EXHIBIT

THE SPEAKER: The next item is new business, and the Speaker would like to make an announcement. I shall request that all of you, if possible, visit the special exhibits that are prepared for the delegates at four-thirty this afternoon. You know, there has been a great deal of expense in putting on a meeting of this kind and the expense is borne wholly by the technical exhibit, and it should be viewed by the delegates. This afternoon, there will be no one there but the delegates, so if you can be there at four-thirty, we will certainly appreciate it.

XIII. Reports of Reference Committees

THE SPEAKER: Is there any other new business?

If not, we will go on to the report of the Reference Committees. First, is the Reference Committee on Officers Reports. Dr. Day.

XIII-1. ON OFFICERS' REPORTS

XIII-1 (a) SPEAKER'S ADDRESS

LUTHUR W. DAY, M.D.: The Committee on Officers Reports has reviewed the address of the Speaker and agrees with its contents in principle, with the exception of his third recommendation:

"That in keeping with 'the Declaration of Medical Policies' adopted by this House of Delegates last year, we flatly refuse to participate in any future health program that is inaugurated without first having been submitted to our Society for study and approval."

We would suggest for your consideration that instead of going on record in a statement of what we will not do (which report becomes public property), that it might be better for the Michigan State Medical Society to define a policy stating what it will do.

Mr. Speaker, I move the acceptance of this report as modified.

THE SPEAKER: Is there a second to Dr. Day's motion to accept the report as modified?

(The motion was seconded.)

THE SPEAKER: Is there any discussion?

G. L. MCCLELLAN, M.D. (Wayne): May I ask how the gentleman proposes to modify the report?

DR. DAY: It is modified inasmuch as we take issue with the particular recommendation that has been made to the Speaker. We simply do not approve that recommendation.

THE SPEAKER: Is there further discussion?

R. H. PINO, M.D. (Wayne): We have modified that somewhat for the purpose of discussion. That requires discussion, I believe.

THE SPEAKER: Dr. Pino, will you come up here where they can all hear you?

DR. PINO: There may be a minority report given relative to this. I hope so, because this is not a unanimous report. I heard the discussion this morning which presented both sides of the question as to whether or not the medical profession of Michigan should go on record as saying we will not co-operate with the government. Now, there is a proviso in there, except that we are first consulted, and that sounds reasonable. But, if we were to think that through, we must remember that sometimes we cannot have a thing done for the people that ought to be done. The less we say "We shall not," the better, and that is one side of it.

We may have to meet strikes with strikes. However, for the purpose of discussion, and I am sure the majority of this committee are willing to be persuaded, I wish that there might be opinions expressed to the end that if we say what we will do, it might be a better selling point for the medical profession in the long run.

Dr. McClellan has just asked a question, What is it that this committee proposes we shall do? Well, that is a tremendously big order, and when we strive to do something, you know it takes years to get it to come to pass, but there is one thing we can cite as an example and that is the Michigan Medical Service. We said we would do this, and whether it is as good as we would like to have it, it is something accomplished. At least we can say in answer to the Wagner Act, we believe in this; we will do this.

I wish we might have in mind that things are changing all along the line. We are going to change our minds somewhat, too, about things in general, one way or the other. I believe this Society has the ability to set down things that we will do and not have to say what we won't do. At the same time, I will admit it

may be necessary to meet strikes with strikes, so we place this before you for consideration.

I hope it will be discussed. We are willing to be persuaded.

THE SPEAKER: Thank you, Dr. Pino. Is there further discussion? The motion is that the report be approved with the exception of No. 3 in the recommendations.

F. G. BUSSER, M.D. (Wayne): If I may say so, Mr. Speaker, I think that Dr. Day has not presented this so fully as might be desired. I think before this thing can be definitely discussed that he should incorporate in his report the last paragraph of what the committee decided upon last night. I find myself in a position of being in the minority group. I made the suggestion that the words "flatly refuse" be covered in a little more tactful language. I can well understand, after all these years of association with Dr. Ledwidge, that he has the faculty of expressing his ideas in the strongest possible words. While I don't think we can all be Mr. Somebodies, at least we can take the sting out of something and still not weaken our position.

At this particular time as we approach a very critical period in our history, it seems to me that the House of Delegates of this Society has put on record a very definite and at least startling proposition as to how medical care can be provided for the people of the State of Michigan.

The point I want to make is this: I don't think that we should now, by phrase or by action, indicate to the public that this Society is commencing to weaken its position or stand in connection with so-called state medicine. I think the best defense is its very strong offense, and it is for those reasons that I find myself in this not embarrassing, but at least not enviable position, and that I make these few remarks.

I don't think we want to do anything that is going to weaken our position. We have taken a definite stand in state medicine and I don't think we should commence to retrench.

THE SPEAKER: Thank you for your clarification. May the chairman make one statement? A topic once referred to a reference committee on reports cannot be touched by anybody else until such report is made. It is obvious that there is some difference of opinion on one point among the members of the committee.

The Chair would entertain a substitute motion to refer this matter back to the committee for clarification on point No. 3, such clarification to be in typewritten form as a part of the report. Is there such a motion?

R. A. SPRINGER, M.D. (St. Joseph): I will make such a motion.

H. F. DIBBLE, M.D. (Wayne): I second it.

THE SPEAKER: The motion is that this shall be referred back to the committee on point No. 3, and clarification is to be brought in. Is there any discussion?

R. H. PINO, M.D. (Wayne): Mr. Speaker, suppose all we can say is that we believe that it is better to state what we will do for the public record before it becomes a public record, instead of stating what we will not do?

THE SPEAKER: Correct.

DR. PINO: Does our report not do that? Maybe it does that.

W. N. BRALEY, M.D. (Wayne): I felt that the Speaker's statement did say what we would do. It said we would refuse to co-operate unless the plans were submitted for our approval. I don't think it could be clearer than that.

THE SPEAKER: That is not the committee's report. We want the committee's report clarified. Is there further discussion?

(The question was called for.)

THE SPEAKER: All in favor of the substitute motion to refer this back to the committee for clarification on point No. 3, such clarification to be typewritten, say "aye"; opposed? So ordered.

The next order of business is the continuation of the report.

XIII-1 (b) PRESIDENT'S ADDRESS

LUTHUR W. DAY: Your Committee on Officers Reports has reviewed the report of the President and wishes at this time to compliment him on the efficient management of the President's office and accepts his report.

Mr. Speaker, I move the acceptance of this report.

DR. BAILEY (Wayne): I second it.

THE SPEAKER: All in favor of the motion say "aye"; opposed? The motion is carried.

XIII-1 (c) PRESIDENT-ELECT'S ADDRESS

LUTHUR W. DAY, M.D.: Your Committee on Officers Reports has reviewed the address of the President-Elect and wishes him success during his tenure of office.

Mr. Speaker, I move the acceptance of this address.

C. S. RATIGAN, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion? All in favor say "aye"; opposed? The motion is carried.

XIII-1 (d) REPORT OF DELEGATES TO AMA

LUTHUR W. DAY, M.D.: Your Committee on Officers Reports has read the report of the Delegates to the American Medical Association in the Blue Book and listened to the Supplemental Report by Doctor Luce and views with alarm the arbitrary attitude of the officers of the American Medical Association toward the Delegates to the American Medical Association of the Michigan State Medical Society.

Your Committee would like an expression of an opinion from our Delegates to the American Medical Association as to what can be done to mitigate this situation.

We wish to express our confidence in the ability and integrity of our Delegates.

Mr. Speaker, I move the acceptance of the Delegates' report.

C. L. HESS, M.D. (Bay): I second it.

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed? So ordered.

XIII-2. ON REPORTS OF THE COUNCIL

THE SPEAKER: The next order of business is the report of the Reference Committee on Report of the Council. Dr. Barrett of Wayne.

W. D. BARRETT, M.D. (Wayne): Your Committee appreciates the amount of work that has been performed by The Council of the Michigan State Medical Society during the past year.

We agree with the report in its entirety as printed in the Handbook with the exception of: On line 3, paragraph 2, page 36, delete, "That our civilian doctors are able to fit" and substitute, "how ably our civilian doctors fitted."

I move the adoption of this correction as given at this time.

THE SPEAKER: The motion is to accept this portion of the report which has been read with the correction that has been passed.

(The motion was seconded.)

THE SPEAKER: Is there any discussion on this motion? All in favor of the motion say "aye"; opposed? The motion is carried.

DR. BARRETT: While we appreciate the work done by the special committee of The Council on the EMIC Program, yet the committee feels that perhaps further discussion in the House of Delegates should take place before approval of their plan; namely, a, b, c. That if the House of Delegates should not approve the recommendation a, b, c, that we then cease to co-operate with this plan at the end of the specified time; namely, six months after the duration.

I move the adoption of this part of the report.

ARCH WALLS, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed? So ordered.

For your information at this time, I am sure the question is coming up for discussion during the reports of one of our committees.

DR. BARRETT: We feel that an expression of thanks from the Michigan State Medical Society to Parke, Davis and Company for their generosity in purchasing the Early House on Mackinac Island, the scene of Beaumont's first experiments, would be a fine gesture.

I so move.

J. B. RIEGER, M.D. (Wayne): I second it.

THE SPEAKER: Is there further discussion? If not, all in favor of accepting this part of the report with the correction, say "aye"; opposed? It is carried.

DR. BARRETT: For the supplemental report of the Committee, the Committee suggests that questionnaire cards in sufficient number be sent to each county society and that the responsibility of returning these signed cards be left to each society.

I move the adoption of this portion of the report.

J. A. KASPER, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed? The motion is carried.

DR. BARRETT: We recommend the tabling of the Brasie Resolution of 1943 and that specific authority be granted The Council to test the legal rights of certain practitioners; the test to be timed for the most propitious moment.

I move the adoption of this portion of the report.

F. G. BUESSER, M.D. (Wayne): I second it.

T. K. GRUBER, M.D. (Wayne): I would like to have this statement amplified a little bit.

DR. BARRETT: Section 9 of the Supplemental Report from The Council:

"Brasie Resolution of 1943. A special committee (Sladek, Beck, Riley, Witwer) was appointed by the Council to study and report on this proposal to limit Michigan Medical Service to Doctors of Medicine.

"If this Resolution were adopted, it would put Michigan Medical Service out of business. Michigan's successful program of group medical care cannot survive if such peremptory action is taken at this time. The problem outlined in the Resolution was not created by Michigan Medical Service; it represents an ever-increasing growth over the years that is a problem of medicine, for the profession to solve. If you desire Michigan Medical Service, which is our only telling answer to federalization and regimentation, to continue as your bulwark, this resolution should be tabled and in its place specific authority to test the legal rights of certain practitioners—the test to be timed for the most propitious moment—should be granted The Council."

THE SPEAKER: Is there any other discussion?

D. R. BRASIE, M.D. (Genesee): In the first place, I object to the labeling of the Brasie Resolution. As you look back on the minutes of the last meeting, you will see it was introduced as having arisen from the County of Genesee and was not my personal resolution. I would like to see that corrected in the statements that have been made here and in the records. I think that is only right and just.

THE SPEAKER: The Chairman would like to agree with Dr. Brasie on that point. Dr. Brasie is only expressing the viewpoint of the Genesee County and if it is agreeable to the House, those corrections will be made. Is there any objection from the House? (None.)

DR. BRASIE: Further, Mr. Speaker, there has been another statement made here which I did not take up under the report of Dr. Moore. It comes up in this report of the committee. A flat assertion is made that if the osteopaths are excluded from Michigan Medical Service, it will fail and fold up. Gentlemen, that is a flat assertion, not substantiated by any facts. It is not substantiated by anything except the opinion of those men who made it. It should not stand on the records as a statement of fact. It should stand on the records that they wish to put it in as an opinion expressed, if you please.

There are differences of opinion on that subject. This is an opinion, and I think it should be corrected. I won't ask that. I just want it in the records that it is an opinion and cannot stand as a fact. There is no substantiation of it.

Furthermore, the statement was made that the fact that osteopaths now practice under Michigan Medical Service is not the fault of Michigan Medical Service. I take exception to that remark and object to approving this thing as stated. We will have to have a little of the history, very briefly.

There are men in this House who remember that when the Michigan Medical Service proposition was presented, one of its largest sales arguments was that it would exclude the osteopath. That is one of the big things that sold it to some of the men in the state. That was stated by some of the men who are present here today. Within six months after the formation of Michigan Medical Service, they saw fit to yield to pressure. The pressure was that it was having a hard time surviving, the Ford contract was coming up, and the Ford Personnel Division insisted that payment be made to any form of practitioner, and they even paid chiropractors.

Now bear in mind, Michigan Medical Service didn't pay them, but the fees these men charged were deducted from the payment of Ford Motor Company made to Michigan Medical Service, so they could get up before you gentlemen and say, "We didn't do that." They subterfuged. So the records give the denial to the assertions that have been made today. It is in the record. We just want to keep the records straight.

Incidentally, you have a new management that has done very well in many respects. It did not create this precedent, but some of the men on the board that did create it are still on the board, and some of the officers of this Society are still here that helped create it, and the fact should be so recorded.

We have listened to a lot of eyewash on this subject because of fear. Fear! You have heard an address this morning on what was done with the same act that we have in the State of Michigan. I ask that the portion of this Committee's report which refers to the fact or to the alleged fact that it was not the fault of Michigan Medical Service that the osteopaths were included, be deleted. Otherwise, you are not being consistent.

Now, what you do with a situation in the future is not to be discussed here, I understand. We can't go into that. But I ask that that portion of this report of the committee that asserts Michigan Medical Service is not responsible for this condition, being obviously an untruth and not intentional, but perhaps an overlooking of past history, be deleted. I so move. I move that as an amendment to the report.

DR. LOUPEE (Cass): I support the motion.

THE SPEAKER: Is there further discussion?

DR. LUCE (Wayne): As a senior delegate to AMA, I would like to ask a question of Dr. Brasie; would he be content with the acceptance of his first recommendation that the committee make "in our opinion" a deletion.

DR. BRASIE: Dr. Luce, the question of "in our opinion" applied to the one specific statement, "but this resolution would drive Michigan Medical Service out of business." That was a statement of fact, and in that respect, I am content, but as far as including the rest of the report, whitewashing the fact that the Michigan Medical Service allegedly did not do this, I would not be content.

THE SPEAKER: In other words, you do not ask for the deletion of the other part?

DR. BRASIE: I did ask for the deletion of the other part. I asked for the deletion of that portion of the report which states—

THE SPEAKER: You mentioned two things: First was "in our opinion—"

DR. BRASIE: And, you granted that?

THE SPEAKER: No.

DR. BRASIE: I am sorry, but—

THE SPEAKER: You asked that the resolution be changed in the record from your name to representa-

tive of Genesee. Is that correct? Second, you called attention to the fact that the statement that the Michigan Medical Service would fail was opinion only, but you did not ask for the deletion. You were satisfied to have that go on the record.

DR. BRASIE: I was not in error in asking it be made an opinion, but if the Chair pleases, I would prefer that be deleted.

THE SPEAKER: We will act on those things separately. The one now is—I don't recall the exact wording you wish to change. . . .

DR. BRASIE: Perhaps it would be more specific. . . .

THE SPEAKER: That, it was not the fault of the Michigan Medical Service. Do you want to delete that?

DR. BRASIE: I want that statement and the explanation of it deleted.

THE SPEAKER: Will the chairman of the committee read that portion of the report?

DR. BARRETT:

"If this resolution were adopted, it would put Michigan Medical Service out of business. Michigan's successful program of group medical care cannot survive if such peremptory action is taken at this time. The problem outlined in the resolution was not created by Michigan Medical Service; it represents an ever-increasing growth over the years that is a problem of medicine, for the profession to solve. If you desire Michigan Medical Service, which is our only telling answer to federalization and regimentation, to continue as your bulwark, this resolution should be tabled and in its place specific authority to test the legal rights of certain practitioners—the test to be timed for the most propitious moment—should be granted The Council."

DR. BRASIE: I can only legitimately ask that those two sentences at the beginning be deleted; that the following paragraphs which are necessary to the consideration of the resolution be preceded by, "in the opinion of the committee."

THE SPEAKER: Now, Dr. Barrett, will you read that portion again that Dr. Brasie has now mentioned?

DR. BARRETT:

"The problem outlined in the resolution was not created by Michigan Medical Service; it represents an ever-increasing growth over the years that is a problem of medicine, for the profession to solve."

DR. BRASIE: Those two sentences only, because they go together. If that is deleted, it doesn't change the sense.

THE SPEAKER: The amendment then, as it is now stated, would be to delete this portion of the report: "The problem outlined in the resolution was not created by Michigan Medical Service; it represents an ever-increasing growth over the years that is a problem of medicine, for the profession to solve."

DR. LOUPEE: I second that.

THE SPEAKER: Is there any discussion on the amendment?

R. L. NOVY, M.D. (Wayne): The first two comments Dr. Brasie made in regard to the motion and in regard to the fact of the statement being a question of opinion, are absolutely correct.

The second statement he made is correct and his deletions, I believe, of that portion are proper. I do not wish that there be a motion to carry the implication that the Michigan Medical Service is responsible for the whole problem. It brought the problem to a head. I do not wish to make any comment that Michigan Medical Service in the first couple of months in allowing deductions to be made to the Ford Motor Company for osteopaths was not good. This problem should have been met at that time. It was not met at that time and, as we mentioned to you a year ago, it is a question of that having been established.

I do want to make sure this motion does not imply that the Michigan Medical Service is responsible for the problem, or rather, I want to say it has brought the problem to a head. I concur in Dr. Brasie's statement with that qualification.

THE SPEAKER: Is there any further discussion on the amendment? All in favor of Dr. Brasie's amendment to delete this portion say "aye"; opposed? The motion is carried.

We have to vote now on the original motion to accept this portion of the report with the amendment. Is there any discussion as to accepting the report as amended? All in favor say "aye"; opposed? It is carried.

DR. BARRETT: We recommend that a bloc be inserted in the Michigan State Medical Society JOURNAL expressing our gratitude for the Biddle bequest.

I move the adoption of this portion of the report.

THE SPEAKER: Is there a second?

B. G. HOLTOM (Calhoun): I second it.

THE SPEAKER: Is there any discussion on this motion? All in favor of the motion say "aye"; opposed? The motion is carried.

DR. BARRETT: The Committee read the resolution of Dr. Gruber for the recommendation of the Council in the Handbook and moves adoption by the House of Delegates.

Should this resolution be read?

THE SPEAKER: Yes. This is the resolution that came as a part of the recommendation of the Council and therefore was referred to this Committee. It came as the result of the recommendation of the Council and then was referred to this Committee rather than the Resolution Committee.

DR. BARRETT: Resolution No. 23.

"WHEREAS, a complete stenographic report of every resolution, motion, and word spoken during the Annual Session of the House of Delegates of the Michigan State Medical Society is transcribed and retained in the permanent archives of the Society, available for study by any member of the State Society at any time; and

"WHEREAS, a national need exists for saving vital paper stock such as is used in THE JOURNAL of the Michigan State Medical Society, and

"WHEREAS, The Council of the Michigan State Medical Society recommends that the considerable expense of publishing every word as spoken before the MSMS House of Delegates in THE JOURNAL be curtailed at this time if possible, therefore be it

"RESOLVED, that the House of Delegates instruct The Council to condense the annual transactions of the House of Delegates as published in THE JOURNAL of the Michigan State Medical Society."

I recommend the adoption of this resolution.

C. L. HESS, M.D. (Bay): I second the motion.

G. L. MCCLELLAN, M.D. (Wayne): I listened to Dr. Gruber yesterday afternoon, or yesterday evening, condemning the American Medical Association for this very thing. In very stirring language, he aroused us to a state of rebellion. Now, we are asked that the report of the Michigan House of Delegates be curtailed. It seems to me that the same objective might be reached, Mr. Speaker, if we become a little more economically-minded and less scientifically-minded and for an issue or two, let's curtail the space given the membership record and let's have the membership acquainted with what we are doing.

THE SPEAKER: May the Chair attempt to clarify one point? I believe there is this difference: According to this resolution, there would be at all times a transcript of every word spoken here in the Executive Office at Lansing and those records are always open for review by any member of our Society. Is that true of the American Medical Association, Dr. Luce?

DR. LUCE: Mr. Speaker, I believe that is true of the American Medical Association, but if I may be allowed to comment, that doesn't do us any good. It is there, but who reads it?

THE SPEAKER: Do you mean in the American Medical Association or here at home?

DR. LUCE: Both.

THE SPEAKER: Then, without seeming to be argumentative but merely pointing out some of our difficulties, how could a senior delegate to the American Medical Association ask that this be deleted last night?

It is for that very reason that is being done, I assure you, in part. It is not the whole reason, that unless we do have some prerogative for cutting some of this down, it will mean many more executive sessions of the House. Our policy has been, as you know, open house for every member of our Society, so we may all know and become interested in what is going on.

I am not arguing for the members, but for the things that come up. Is there further discussion?

DR. LUCE: Mr. Speaker, may I have the question repeated again for the sake of making the record more clear?

DR. BARRETT:

"That the House of Delegates instruct the Council to condense the annual transactions of the House of Delegates as published in THE JOURNAL of the Michigan State Medical Society."

DR. LUCE: My comments further would be that I have asked that only that portion of my report be deleted. Further if I may at this time make an amendment to that motion, I would say, make an amendment to that motion that this be applicable to the sessions of the year of 1944; this session at the present time as it is now, not to go through all sessions of the future, only the year of 1944.

THE SPEAKER: I don't quite understand you. If I understand what you mean, this would then go into this resolution and it would affect not next year, but this year.

DR. LUCE: I believe the resolution refers to the minutes of this meeting.

THE SPEAKER: You mean this resolution would be incorporated in the handbook as part of our By-Laws?

DR. LUCE: May I ask that, that last for all time?

THE SPEAKER: Until changed by further motion?

DR. LUCE: I would make a motion as an amendment that this particular statement in this resolution be only applicable to this one session of 1944.

THE SPEAKER: Then, no particular date would be referred to.

DR. LUCE: Have it qualify the whole resolution as it now stands. That would be an established policy for the future until further rescinded. I am limiting it to one year's time.

THE SPEAKER: Dr. Luce wishes to offer an amendment to limit this resolution, if passed, to 1944 only.

DR. LUCE: Whether passed or not, I am offering that as an amendment and they can pass it or not, afterwards.

DR. NOVY: How much more would it cost to print the whole thing, and why does Dr. Luce, at this particular time, when things are so crucial, want anything deleted? If it is going to cost \$50 more, why—. The whole motion doesn't stand well with the various discussions Dr. Luce had about the American Medical Association.

THE SPEAKER: The Chairman doesn't know, and I am not sure anybody knows how much difference it would make.

DR. NOVY: Are we quibbling about ten dollars or ten cents or ten thousand dollars?

THE SPEAKER: The Chairman refuses to answer that. Dr. Luce may answer the second question.

DR. LUCE: May I have the question repeated?

THE SPEAKER: Dr. Novy, do you wish to repeat that part?

DR. NOVY: I would like Dr. Luce to answer me at this time, why, when we are so much interested in all the transactions that are going on, he is anxious to save the paper and fifty dollars or fifty cents, or whatever it may be, for us just this one year, setting aside the very thing he spoke so well about, that everybody be thoroughly acquainted in every respect with what goes on. It seems to me that this is more important than the idea of saving a little paper and changing temporarily the very principles you fought for yesterday on the floor.

DR. LUCE: Mr. Speaker, I think I am being identified as the sponsor of the motion, which I am not. I would like to say, Mr. Speaker, that if anybody else uses the word "critical" here during this session, I am going to leave the session.

DR. GRUBER: This has been tied to me. The resolution came from the Council and we in the Council of the Wayne County Medical Society are not in a position to enter resolutions. They had considered the situation and felt they would like to conserve paper and maybe a few nickels, and I was asked to introduce the resolution. I have no feeling one way or the other. I simply brought it to the attention of the House of Delegates at the request of the Council. It is the judgment of the Council that this should be done. I am not going to say what my judgment is going to be. I will vote on the subject, but I do it just as a favor to the Council of the Wayne County Medical Society.

THE SPEAKER: Thank you, Dr. Gruber. I would like to substantiate that statement Dr. Gruber has made. This was a recommendation of the Council. This requires a resolution to bring it before the House. The Council is not in a position to make resolutions. Therefore, Dr. Gruber presented it, for which he has suffered.

I told you a moment ago that saving the paper was in part the reason for this. I would like now to call on Dr. Foster to amplify the reasons for this.

THE SECRETARY: Mr. Speaker, a number of factors enter into this, I believe, and the first one is, there are certain postal regulations that there must be as much reading material in THE JOURNAL as advertising material. THE JOURNAL for a long time, has been going into the red, as you know from the financial report. A dollar and fifty cents from your dues has been allocated to THE JOURNAL which shows up as a source of revenue.

However, for the last year, THE JOURNAL has made a definite profit by so meeting the problems of reading material in contrast to the advertising material which has increased tremendously. That is not the only point.

The second point refers to requests of members who desire to speak here "off the record."

DR. BRASIE: There are other ways of deleting that which should not go into the records. You can go into an executive session or it can be deleted from the records at the discretion of the House.

THE SPEAKER: I might say we are rather off-color, all of us. We really should be discussing Dr. Luce's amendment. So let's confine our discussion to that part for the moment.

Dr. Luce's amendment was, this resolution be so amended as to apply to the year 1944 only. Is there further discussion on Dr. Luce's amendment?

F. J. O'DONNELL, M.D. (Alpena): I was going to offer this as a suggestion or as a question, whether it wouldn't be possible that before you stated the transcript of the record would be in the state office prior to our organization, why a short digest of the doings of the House of Delegates could not be published in THE JOURNAL and a mimeographed copy of the exact word-for-word proceedings transmitted to the secretary of every county medical society so we will have it in our hands if we want it.

THE SPEAKER: You are out of order, but your discussion is good. We will take it up when we finish the other.

(The question was called for).

THE SPEAKER: All in favor of Dr. Luce's amendment say "aye"; opposed "no." I believe we will have to take a standing vote. All those in favor of Dr. Luce's amendment please rise. (Eighteen members arose.)

All those opposed, please rise. The motion is lost.

Now, we are ready for further discussion on Dr. Barrett's motion to pass this resolution which is giving the Secretary the right to condense the proceedings of the House as published in THE JOURNAL.

R. S. BREAKEY, M.D. (Ingham): This vote on the present motion is that there shall be no condensation, is that right?

THE SPEAKER: Correct. Is there further discussion?

R. J. ARMSTRONG, M.D. (Kalamazoo): I would judge by the vote on the amendment that there is confusion in the House. If you pass this thing, don't let it go longer than a year, for the sake of freedom. Let's deny this motion.

THE SPEAKER: Thank you. The point has already been settled. It wouldn't apply just for this year, so it is only a question now of this resolution.

R. A. JOHNSON, M.D. (Wayne): I would like to ask whether it has been the policy in the past to make deletions on the deliberations of this body?

THE SPEAKER: I think I will ask the Secretary that, although I think I can answer it myself.

THE SECRETARY: The transcript that will result from the stenotypist's notes will total about 256 pages a year. It takes three days to edit them. Bill Burns and I spent three days completely in the editing of these. If they were published as they came back, many members of the House would hate to see in writing what they ad lib from this platform, and I will say frankly, there have been many paragraphs deleted; not because of their context, but because of the way the case was stated, and the English used, but there has never been a deletion of action or opinions expressed. However, there have been pages of deletions of words. As to the point I made a minute ago of concealing anything, I would like, if I may, Mr. Speaker, in justification to the Executive Officers, say that the secretaries have not concealed anything.

My statement was, I believe, that this was presented by Dr. Luce because he asked that it not be published for that reason. The secretaries have no discretion in concealing anything. They simply carry out duties and there has been no concealing on the part of the secretaries.

DR. JOHNSON: Would this present vote now before the House change that?

THE SPEAKER: Yes, it definitely would. That is, if I understand it correctly.

R. V. WALKER, M.D. (Wayne): It seems to me there are two things here. One is the saving of space and the other is the question of publicity. The subscription list of THE JOURNAL is open not only to members of the Michigan State Medical Society, but to any one who will purchase THE JOURNAL; it is a matter of keeping this from the general public. There are things here which possibly should not go to the osteopaths, as for instance, the motions that are going to take place at the proper time. Those would all be sent to the membership of the medical societies if the proceedings were published as a separate issue and sent only to the members and not the subscription list of THE JOURNAL.

THE SPEAKER: Is there further discussion?

(The question was called for).

DR. ARMSTRONG: I don't think we need to worry about any publicity. The short time I have been in politics, it has always got out before I left the hall. There is always somebody to tell the opposition.

As far as saving paper, the records are kept in Lansing. We would have to spend gas to go up there. What do you want to do—save paper or save gasoline?

THE SPEAKER: Are you ready for the question?

(The question was called for).

THE SPEAKER: The question is on the motion as presented by Dr. Barrett, chairman of the committee, to give power to delete from the transcript as published in THE JOURNAL. All in favor of the motion say "aye"; opposed "no." The noes have it.

DR. LOUPEE: May I ask for a ruling?

THE SPEAKER: Yes.

DR. LOUPEE: As a result of this vote, does it now mean the secretaries have no right to delete a single word that is expressed here, or do they have a right to edit these reports?

THE SPEAKER: It is the understanding of the Chair, the procedure will be the same as it has been before. Is that the understanding of the House? (Agreed.)

DR. BARRETT: I move the adoption of The Council Report, as amended.

(The motion was seconded).

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed "no." The motion is passed.

The next order of business is the report of the Reference Committee on Standing Committees. Dr. Donald Beaver of Wayne.

XIII-3. ON STANDING COMMITTEE REPORTS

DONALD BEAVER, M.D. (Wayne): The Reference Committee on Reports of Standing Committees met in Room 126, Pantlind Hotel, September 25, 1944.

Those present were: M. G. Becker, M.D., Milton A. Darling, M.D., R. T. Lossman, M.D., W. B. Harm, M.D., F. J. O'Donnell, M.D., Carl Ratigan, M.D., and Donald C. Beaver, M.D., chairman.

The annual reports of each of the standing committees for 1944 were carefully considered and the following actions were adopted:

The report of the Legislative Committee was approved as published in the Handbook, page 51.

Mr. Speaker, I move the adoption of this committee's report.

A. E. STICKLEY, M.D. (Ottawa): I second it.

THE SPEAKER: Is there any discussion on this part of the report? All in favor say "aye"; opposed? Carried.

DR. BEAVER: The Report of the Committee on Distribution of Medical Care was approved as published in the Handbook, page 61.

Mr. Speaker, I move the adoption of this committee's report.

CARL RATIGAN, M.D., (Wayne): I second the motion.

THE SPEAKER: Is there any discussion? All in favor say "aye"; opposed? The motion is carried.

DR. BEAVER: The report of the representatives to the Joint Committee on Health Education was approved as published in the Handbook, page 58, with the notation that this committee be urged to carry out the recommendations which it had made.

I move the adoption of the committee's report with the changes made by the committee.

THE SPEAKER: The only changes are to carry out the recommendations.

J. A. KASPER, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion. The motion is to accept this report plus the recommendation of the Reference Committee that they carry out their own recommendations.

All in favor say "aye"; opposed? Carried.

DR. BEAVER: The report of the Medical-Legal Committee was approved as published in the Handbook, page 79.

I move the adoption of this committee's report.

ARCH WALLS, M.D. (Wayne): I second it.

THE SPEAKER: All in favor of the motion say "aye"; opposed "no." Carried.

DR. BEAVER: The report of the Preventive Medicine Committee was approved as published in the Handbook, page 58.

Mr. Speaker, I move the adoption of this committee's report.

DR. JOHNSON (Wayne): I second it.

THE SPEAKER: All in favor of this motion say "aye"; opposed? Carried.

DR. BEAVER: The Committee on Preventive Medicine is divided into nine subdivisions and each of these subcommittees' reports were acted upon as well. I will now begin the reporting of the various committees.

First, is the Cancer Committee. The Reference Committee recommended that the Cancer Control Committee be highly commended for its constructive work in the publishing of the *Cancer Manual* and that a broader distribution of the *Manual* be attempted amongst doctors of medicine, nurses, and social workers as suggested in the Committee's report and that the entire report of the committee be approved as published in the Handbook, page 49.

Mr. Speaker, I move the adoption of the recommendation of the Reference Committee and the changes made by the Reference Committee on the report of the Cancer Control Committee.

DR. WALLS (Wayne): I second it.

THE SPEAKER: Is there any discussion on this point? All in favor, please say "aye"; opposed? It is carried.

DR. BEAVER: Now, I would move that the reports of all the other standing committees be accepted as published in the Handbook.

DR. RATIGAN (Wayne): I second the motion.

THE SPEAKER: Is there any discussion? All in favor say "aye"; opposed? It is carried.

Thank you, Dr. Beaver. The next order of business then, is the report of the Reference Committee on Special Committees. Dr. E. A. Oakes will please take the Chair.

(The Vice-Speaker assumed the Chair).

XIII-4. ON REPORTS OF SPECIAL COMMITTEES

A. V. WENGER, M.D. (Kent): Your Reference Committee commends the various special committees on the tremendous tasks well done in the preparation of their reports as printed in the Handbook. The first report is the report of the Committee on Nurses' Training Schools. The Committee approves the report as printed in the Handbook on page 51.

Mr. Speaker, I move the adoption of the report.

THE CHAIRMAN: Is there a second?

(The motion was seconded).

THE CHAIRMAN: All in favor say "aye"; opposed "no." It is carried.

DR. WENGER: The Report of the Conference Committee on Prelicensure Medical Education. The Committee approves the report as printed in the Handbook. I move the adoption of this report.

J. O. WETZEL, M.D. (Ingham): I second it.

THE CHAIRMAN: Is there any discussion? All in favor respond by saying "aye"; opposed "no." Carried.

DR. WENGER: The third is the report of the Radio Committee. The Committee approves the report as printed in the Handbook.

Mr. Speaker, I move the adoption of the report.

THE CHAIRMAN: Do I hear a second?

J. J. O'MEARA, M.D. (Jackson): I second it.

THE CHAIRMAN: Is there any discussion? If not, all in favor respond by saying "aye"; contrary "no." Carried.

DR. WENGER: The report of the Advisory Committee to the Woman's Auxiliary, together with the supplemental report made orally by Dr. Reeder, chairman of the committee. The Committee approves the report as printed in the Handbook.

Mr. Chairman, I move the adoption of the report.

ALFRED LABINE, M.D. (Houghton): I second the motion.

THE CHAIRMAN: Is there any discussion? If not, all in favor respond by saying "aye"; contrary "no." Carried.

DR. WENGER: The report of the Beaumont Memorial Committee. That is found on page 50 of the Handbook. This report is approved by the Committee.

I move the adoption of the report.

L. J. GARIEPY, M.D. (Wayne): I second it.

THE CHAIRMAN: Any remarks? All in favor respond by saying "aye"; contrary "no." Carried.

DR. WENGER: The report of the Committee on Procurement and Assignment of Doctors of Medicine is printed on page 76 of the Handbook. The Committee approves the report.

Mr. Chairman, I move the adoption of the report.

F. H. DRUMMOND, M.D. (Bay): I second the motion.

THE CHAIRMAN: All in favor, respond by saying "aye"; contrary "no." Carried.

DR. WENGER: The report of the Joint Committee with the State Bar of Michigan. The Committee approves the report as printed in the Handbook on page 51.

Mr. Chairman, I move the adoption of the report.

C. A. PAUKSTIS, M.D. (Mason): I second it.

THE CHAIRMAN: All in favor respond by saying "aye"; contrary "no." Carried.

DR. WENGER: Mr. Speaker, I now move the adoption of the report as a whole.

DR. O'DONNELL (Alpena): I second it.

THE CHAIRMAN: Is there any discussion? All in favor respond by saying "aye"; contrary "no." Carried.

XIII-5. ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

THE CHAIRMAN: Next is the Committee on Amendments to the Constitution and By-laws. Dr. Hess of Bay.

XIII-5 (a). CONSTITUTIONAL AMENDMENTS PRESENTED IN 1943

DR. HESS: Please turn to page 18 in the Handbook. This is the first amendment to the Constitution. This deals with doctors in medical schools who are called to the Army for military services before they have an opportunity to hang up their shingle and start their private practice. I will read part of the Constitution to show how this subparagraph applies.

XIII-5 (a). CONSTITUTION—ARTICLE III, SECTION 4

Page 81, Article III, Section 4, in the middle of the page:

"Associate Members—County Societies may elect as Associate Members"—(then to subparagraph No. 4) "Physicians not engaging in any phase of medical practice."

Now, the addition of the subparagraph reads this way:

"5. Physicians, residents of the State of Michigan, for the period of time they are in active Military Service of the United States previous to their engaging in active practice."

Mr. Speaker, I move the adoption of this report.

(The motion was seconded).

THE CHAIRMAN: All those in favor, respond by saying "aye"; contrary "no." Carried.

XIII-5 (a). CONSTITUTION—ARTICLE III, SECTION 4

DR. HESS: Amendments No. 2 and No. 3 both cover the same subject and deal with active members who are out of practice because of long standing illness. Again, that applies to Article III, Section 4, and in that case, the county society may elect as Associate members,

"6. Active Members, by transfer, for the period of time they are temporarily out of active practice on account of protracted illness."

The Committee recommends the adoption of Amendment No. 2.

Mr. Speaker, I move the adoption of this resolution.
(The motion was seconded.)
THE CHAIRMAN: Is there any discussion? All in favor respond by saying "aye"; contrary "no." Carried.

XIII-5 (a). CONSTITUTION—ARTICLE III, NEW SECTION 8

DR. HESS: Item No. 4, Page 18, bottom of the page: "Amend Article III by adding a new Section to be known as Section 8, to read as follows:"

Now, this deal with life members. The Committee recommends the deletion of item (c). I will read the amendments (a) and (b) as recommended by the Committee:

"Life Members. A physician who has attained the age of seventy years or more and maintained an active membership in good standing for ten years or more in the State Society may, upon application and recommendation of his County Society be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing.

"The County Society of such member shall make request for certification, in writing, to the Secretary of the State Society thirty days or more in advance of the Annual Session."

The part that is deleted is that this member should not apply or be incorporated in the Constitution until at the Annual Session following the termination of the present World War. The original idea was it would decrease the number of paying members and thus deplete our treasury.

Since last year, I have been able to get a little more information as to probably how many members this would affect, and from the information I have been able to get—however, it is very difficult to determine—I do not think that more than perhaps thirty members would be involved and it would appear that life members of the age of seventy are entitled to payment of their dues and the treasury probably could stand that charge.

Therefore, the Committee recommends the adoption of (a) as read.

Mr. Speaker, I move the adoption of this resolution as revised.

THE CHAIRMAN: We will vote an (a). Is there a second?

L. W. GERSTNER, M.D. (Kalamazoo): I second it.

THE CHAIRMAN: All in favor respond by saying "aye"; opposed, "no." Carried.

DR. HESS: Amend Article III, Section 1 by adding to the list of memberships, the following:
"Life Members."

The present Section 1 reads as follows:

"This Society shall consist of active members, honorary members, associate members, retired members, and members emeritus."

Life Members are being added by this resolution.

Mr. Speaker, I move the adoption of this resolution.

J. J. WALCH, M.D. (Delta-Schoolcraft): I second it.

THE CHAIRMAN: All in favor respond by saying "aye"; opposed "no." Carried.

XIII-5 (a). CONSTITUTION—ARTICLE VIII, SECTION 2

DR. HESS: No. 5, at the bottom of page 19. Amend Article VIII, Section 2, to read as follows:

"The House of Delegates at each Annual Session shall elect the President-Elect, the Speaker and Vice Speaker of the House of Delegates, and the Councilors. These officers shall be installed in the general meeting at which the reports of the House of Delegates are received. They shall serve until the corresponding time of the next annual session except that the Councilors shall serve for five annual sessions. The terms of the Councilors shall be arranged so that not more than four terms expire normally at any annual session. All these officers shall serve until their successors are elected and take office."

"At the annual session next following his election the President-Elect shall be installed into and assume the office of Presidency immediately following the annual address by the retiring President and shall serve until the corresponding time of the next annual session. This assumption of office shall occur in the general meeting at which the reports of the House of Delegates are received.

"If no general meetings are held at the annual session, then induction into the office of the incoming president and the newly-elected officers shall be in the last meeting of the annual session of the House of Delegates.

"The Secretary, the Editor of THE JOURNAL and the Treasurer shall be elected by the Council in its annual meeting in January of each year. They shall take office immediately and serve for a term of one year or until their successors are elected and take office."

The reason for this proposed amendment was, because in the present constitution, the section states that the President shall be elected each year, which of course is not true. The President retires and the President-Elect fills the vacancy. Also, the time when these officers take office is not very clear and the intent is to specify just when an officer takes his office. This is approved by the Committee.

Mr. Speaker, I move the adoption of this resolution.

THE CHAIRMAN: There is a motion before the House. Do I hear a second?

C. A. PAUKSTIS, M.D. (Mason): I second it.

THE CHAIRMAN: Is there any discussion? If not, all in favor respond by saying "aye"; contrary "no." Carried.

XIII-5 (b). AMENDMENT TO BY-LAWS PRESENTED IN 1943

DR. HESS: Page 20, referring to the Committee on Ethics. This was referred back to the Special Committee last year and was considered in the proposed legislation on procedures on ethics to be taken up and considered this year. That will be taken up in a moment.

XIII-5 (b). BY-LAWS—CHAPTER 8, SECTION 4

The next resolution deals with disabled veterans: (No. 2)

"WHEREAS, Every reputable doctor of medicine under license to practice medicine and surgery and midwifery by authority of the Michigan State Board of Registration in Medicine, is eligible for active membership in a component county society as provided in the Constitution, Article III, Section 2, and By-Laws, Chapter 9, Section 3, irrespective of his being in active practice, although if not in active practice, he may be elected as Associate Member at the option of the component County Society as provided in the Constitution, Article III, Section 4, and

WHEREAS, Active Members, becoming totally disabled while on active duty in the military forces of the United States should have their state dues and assessments remitted, be it

"RESOLVED, That Chapter 8, Section 4 of the By-Laws be changed to read as follows:

"An active member in good standing shall not be required to pay his annual state dues and assessments during the years he is on active duty in the military forces of the United States and during the years he may be totally disabled immediately following such duty."

This amendment was revised as to wording. Mr. Speaker, the Committee recommends the adoption of this resolution as read and I move the adoption of the resolution.

THE CHAIRMAN: There is a motion before the House. H. D. DYKHUISEN, M.D. (Muskegon): I don't find the last proposed amendment printed in our Handbook.

DR. HESS: This is pertaining to our By-Laws. Only those pertaining to the Constitution are printed in the Handbook.

DR. DYKHUISEN: We have a proposed amendment to Chapter 6 of the By-Laws, but not this one.

DR. HESS: This was read. This pertains to the By-Laws, not the Constitution. A proposed change to the Constitution must be laid over for one year. The proposed amendments to the By-Laws are referred to the Committee and may be reported on at that same session.

(The motion was seconded.)

THE CHAIRMAN: Is there any further discussion? All in favor respond by saying "aye"; contrary "no." Carried.

XIII-5 (b). BY-LAWS—CHAPTER 6, SECTION 6

DR. HESS: Resolution No. 4.

"RESOLVED, That the name of the 'Committee on Cancer,' as given in Chapter 6, Section 6 of the By-Laws, be changed to the present name of this Committee and read as follows: 'Committee on Cancer Control.'"

I move the adoption of this resolution.

V. N. BUTLER, M.D. (Wayne): I second it.

THE CHAIRMAN: Any discussion? If not, all in favor respond by saying "aye"; opposed? Carried.

DR. HESS: Resolution No. 5.

XIII-5 (b). BY-LAWS—CHAPTER 3, SECTION 7m

"RESOLVED, That Chapter 3, Section 7, paragraph m, first sentence of the By-Laws have the words 'session' and 'meeting' interchanged, so that the first sentence shall read as follows: 'The Election of officers shall be held at the last meeting of the House of Delegates at the Annual Session.'"

The Committee has approved this resolution. Mr. Speaker, I move the adoption of this resolution.

L. J. BAILEY, M.D. (Wayne): I second it.

THE CHAIRMAN: All in favor respond by saying "aye"; opposed? Carried.

XIII-5 (b). BY-LAWS—CHAPTER 6, SECTION 5

DR. HESS: Resolution No. 6.

"WHEREAS, It is desirable to clarify the appointment and the length of terms of representatives on the Joint Committee or Health Education, be it

"RESOLVED, That Chapter 6, Section 5 of the By-Laws be revised so that it shall read as follows:

"The Society's representatives on the Joint Committee on Health Education shall consist of five members, appointed by the President with the approval of the Council, each member to serve for a five-year term, so staggered that one member is selected annually, provided that in 1944, the term of one member shall be for five years, one for four years, one for three years, one for two years, and one for one year. In case a vacancy occurs, the President shall appoint a successor to serve the unexpired portion of the term."

The Committee made slight revisions in the wording.

Mr. Speaker, I recommend its adoption.

A. E. CATHERWOOD (Wayne): I second it.

THE CHAIRMAN: All those in favor respond by saying "aye"; opposed? Carried.

XIII-5 (b). BY-LAWS—CHAPTER 6, SECTION 7

DR. HESS: Resolution No. 7.

"WHEREAS, The present Committee on Postgraduate Medical Education now consists of twelve members including a chairman and an assistant chairman and the length of the term of a member should be more clearly specified, be it

"RESOLVED, That Chapter 6 Section 7 of the By-Laws have the first paragraph deleted and the following substituted therefor:

"The Committee on Postgraduate Medical Education shall consist of twelve members, appointed by the President with the approval of the Council, each member to serve for a three-year term, so staggered that four members are selected annually, provided that in 1944 the term of four members shall be for three years, four for two years and four for one year. In case a vacancy occurs before the expiration of a member's term, the President shall appoint a successor to serve the unexpired portion of the term."

Those of you who have read the By-Laws know the present way is, there are twelve members actually serving on the Committee. That is provided for in the resolution. Also, that the length of terms are not specified, but it is customary for them to serve three terms.

This has been approved by the Committee.

Mr. Speaker, I move the adoption of this resolution. (The motion was seconded.)

THE CHAIRMAN: Was that voted on before? "aye"; opposed? Carried.

XIII-5 (b). ETHICS—BY-LAWS—CHAPTER 9, SECTIONS 3 TO 10 INCLUSIVE; CHAPTER 5, SECTION 4; CHAPTER 6, SECTION 9.

DR. HESS: The last resolution deals with the procedure on ethics. The resolution as presented looks rather simple. I wish to say, we certainly wish the process of writing it were equally as simple. It seems a number of attempts were made to change even one word. It is necessary to reread the entire Constitution and By-Laws to be sure there is no conflict. There was considerable discussion on this resolution.

I will read the resolution as revised by the Committee and then bring up the certain points.

Resolution No. 3.

"WHEREAS, The Council has appointed a Special Committee to make a critical survey of the By-Laws governing the procedures on unethical conduct and to recommend changes for the purpose of clarification and simplification of the procedures, and

"WHEREAS, The present rules provide that a member, disciplined by his component county society, may appeal, first to the Council of his District, then to the Council, and finally to the Judicial Council of the American Medical Association, and

"WHEREAS, A disciplined member should be allowed to appeal directly to the Council, so that the Councilor from his district may sit without prejudice at the hearing on an appeal which such member may make to the Council, and

"WHEREAS, It is desirable to specify the length of term of members of the Committee on Ethics of the State Society and to clarify the duties of the Committee, be it

"RESOLVED, That Chapter 9, Section 3 of the By-Laws have the third sentence of the first paragraph deleted and the procedure on disciplinary action by component county societies amended, so that Section 3 shall read as follows:

"Each component county society shall be the judge of the qualification of its own members, but as such societies are the only portals to this Society and to the American Medical Association, every reputable practitioner of Medicine who meets the requirements specified in the Constitution, Article III, Section 2, shall be eligible to active membership.

"A component county society may expel, suspend, or otherwise discipline a member under such procedure as is specified in its Constitution and By-Laws, provided he is served by registered mail with a written copy of the charges preferred against him, and given at least 30 days' notice of a hearing at which he may offer defense against such charges. He may employ counsel. Efforts at conciliation and compromise shall precede all hearings.

"A member under disciplinary action may appeal to the Council of the State Society. However, such disciplinary action shall remain in effect during the time an appeal is pending. A report of the action taken shall be made by the component county society within 30 days to the Secretary of the State Society."

May I make a few comments on that portion which deals with the officials of the component societies? It is proposed not to limit action and the rights of component societies any more than necessary, and keep it as simple as possible. It is specified a County Society may limit their procedure as specified in the Constitution and By-Laws. It is possible that the counsel for a member may come into a hearing and demand that the rules of the hearing be according to the federal courts and circuit courts and so forth. The rules under which the hearings should be held should be specified in the Constitution and By-Laws and those should prevail.

There are certain provisions here, that this member must be given a written copy of the charges, must be given due notice, and opportunity to defend himself at a hearing. These are so important, if any county society should not permit one of them and if that member appealed either to the counselor or to the judicial council of the American Medical Association, either party may declare a mistrial and refer the case back to the county society.

"BE IT RESOLVED FURTHER, That Chapter 9, Section 4 of the By-Laws be deleted and the following substituted therefor:

"A member of a component county society whose license has been revoked shall be dropped from membership automatically as of the date of revocation."

That is amended in our present chapter as it is here.

"BE IT FURTHER RESOLVED, That Chapter 9, Section 5 of the By-Laws be deleted and the subsequent Sections 6 to 10 be numbered 5 to 9 respectively. Be it further

"RESOLVED, That Chapter 5, Section 2 of the By-Laws have the word 'censor' deleted so that the first sentence shall read as follows:

"Each Councilor shall be the organizer, adviser, and peace-maker for his District.

"BE IT FURTHER RESOLVED, That Chapter 5, Section 4 of the By-Laws be deleted and the procedure on appeal to the Council from disciplinary action be revised, so that Section 4 shall read as follows:

"A member disciplined by his component county society may file an appeal in writing to the Council within ninety days of such disciplinary order. This appeal shall be referred by the Council to the Committee on Ethics of the State Society for investigation and report. After giving at least thirty days' notice to the appealing member and his component county society the Council shall hold a hearing on the appeal under such rules as it may adopt. The Council shall review the record of the original proceedings and may obtain additional evidence. Its decision shall be final except that within the next ninety days a further appeal may be made to the Judicial Council of the American Medical Association."

This has been the revised wording by the Committee in its present form.

"BE IT RESOLVED FURTHER, That Chapter 6, Section 9 of the By-laws be deleted and the following substituted therefor:

"The Committee on Ethics shall consist of eight members appointed by the President with the approval of the Council, each member to serve for a four-year term, so staggered that two members are selected annually, provided that: In 1944 the term of two members shall be for four years, two for three years, two for two years and two for one year. In case a vacancy occurs before the expiration of a member's term the President shall appoint a successor to serve the unexpired portion of the term.

"The Committee shall render advisory opinions on questions of ethics submitted to it by the Council.

"On request of the Council it shall conduct an investigation, under rules approved by the Council, concerning the ethical conduct of a designated member of this Society and report its findings to the Council."

Now, in the resolution read last night, there is one sentence that has been omitted and that has to do with the apparent conflict with other chapters of the By-Laws. As was brought out last night, that Chapter 1, Section 2, provides that the Council may refer to the House of Delegates this recommendation as to what action should be taken on a charter.

It says here that the charter of any component county society may be revoked by the House of Delegates if, after filing with the Secretary of this Society, a written petition signed by the Chairman of the Council pursuant to a resolution adopted by the Council with the affirmative vote of two-thirds of all the members thereof, and, after due notice of hearing and after hearing, thereof, the House of Delegates by a two-thirds vote of its members decides that the provisions of the Constitution and By-Laws of this Society have been breached, or that such County Society has committed acts or conducted itself in conflict with the Constitution and By-Laws or provisions of this Society to such an extent as to make such revocation desirable in the best interests of this Society.

Now, there is another provision for revoking charters on page 96, Section 6:

"It shall upon application provide and issue charters to county societies organized in conformity with this Constitution and By-Laws and revoke such charters when deemed necessary."

There is a third sentence in the By-Laws that also may apply to some of these proceedings. That is also on page 96, Section 4:

"All questions of an ethical nature brought before the House of Delegates or the General Meeting shall be referred to the Council without discussion."

Now, the Committee felt in order that the recommendation of the Council, referring this ethical conduct procedure to the meeting this evening, that it might be discussed, this sentence will be deleted from the proposed change on ethical conduct. Otherwise, it may be interpreted that no discussion of an ethical nature could be permitted on that subject this evening.

Now, of course, procedure is impossible in the discussion coming up this evening. The House of Delegates may refer this matter back to the Council to act in accordance with Section 6, Chapter 5, as given on page 96, "They shall issue charters and revoke such when necessary."

Now, "All unethical conduct shall be referred to the

Council without discussion." Then, that matter may be discussed this evening if the House of Delegates so wishes. Then, you may either act on the matter itself or approve it with the Council.

That is the resolution on ethical conduct as read and approved by the Committee.

I move its adoption.

E. T. MORDEN, M.D. (Lenawee): I second it.

DR. HESS: I move the adoption of this report as a whole.

J. A. KASPER (Wayne): I want to call to your attention that part (c) amendment 4 has not been voted. That is on page 19.

DR. HESS: That reads:

"BE IT RESOLVED, That these amendments shall take effect and be incorporated in the Constitution at the Annual Session following the termination of the present World War."

As I mentioned, as to when the present World War will terminate, that is a question for discussion. The Committee recommends this be deleted.

THE CHAIRMAN: Was that voted on before?

DR. GRUBER: I believe the motion was that this not be adopted.

DR. HESS: I would like to present this although I presented the resolution. I think it is correct, but I will make the motion that this item be not adopted.

DR. GRUBER: I second the motion.

THE CHAIRMAN: Any discussion? All those in favor respond by saying "aye"; opposed? Carried.

DR. HESS: I now move the adoption of this report as a whole.

(The motion was seconded.)

THE CHAIRMAN: All in favor respond by saying "aye"; opposed? Carried.

(The Speaker reassumed the Chair.)

THE SPEAKER: With your permission, the Chairman would like to clarify the order of business a little bit. It is now about twelve twenty-three and we are going to stop promptly at one o'clock. There have been requests to accept a motion for one or two resolutions, so we will have to work extra hard. With your permission, we will change the order of business and ask now for resolutions.

VII-5. CHIPPEWA-MACKINAC COUNTY SOCIETY PROBLEM

DR. GRUBER (Wayne): Last evening we were informed by the Council, and I believe, by the Speaker, that at this evening's session, certain information was to be presented to the House regarding a condition that exists in the Chippewa-Mackinac County Medical Society. The House of Delegates are not acquainted in specific terms with what is to be brought to the attention of the House this evening.

I move that a committee be appointed from the members of the House of Delegates to confer with a committee from the Council this afternoon to bring in a report. That would be a fact-finding committee to bring in a report on this subject for the information of the House of Delegates this evening so as to have in concise form what this proposition is and so as to save a lot of time and discussion on a lot of presentations hit or miss at that time.

A. E. STICKLEY, M.D. (Ottawa): I second that motion.

THE SPEAKER: You have heard the motion. Is it perfectly clear that the Speaker of the House will appoint a committee from this House of Delegates to confer with the Committee of the Council to bring in a report on this Chippewa-Mackinac question. That is, a fact-finding committee. It will have no power to act. Is there any discussion? All in favor of this motion say "aye"; opposed? The motion is carried.

The Speaker will make those appointments at this time. A. E. Catherwood, M.D., of Wayne, Chairman; S. L. Loupee, M.D., of Cass; J. S. DeTar, M.D., of

Washtenaw; F. J. O'Donnell, M.D., of Alpena; C. E. Simpson, M.D., of Wayne. Now, may I say, the fact-finding committee is certainly at liberty to confer with anybody else on the Council or anyone else who can give them information in addition to the committee appointed by Dr. Moore. I am sure most of the committee are pretty familiar with the affair and will be glad to discuss it with you.

THE SPEAKER: This change in the order of business was for a specific purpose. We will recognize Dr. Breakey.

R. S. BREAKEY, M.D. (Ingham): This is in lieu of information just received this morning.

VIII-12. CONSULTATION SERVICE OF UNIVERSITY OF MICHIGAN HOSPITAL

Resolution No. 32 was presented by Dr. Breakey of Ingham County.

There has been reported the adoption of a policy by the administration of the University Hospital to the effect that the staff of the hospital submit reports of findings of patients and further advice relative to treatment of such patients to osteopaths and

WHEREAS, the University Hospital constitutes an integral part of the University of Michigan Medical College a pre-eminent institution in medical education and

WHEREAS, if true that such consultation reports or advice is furnished to osteopaths it would appear to constitute recognition of osteopathy by this leading institution of medical teaching and science and to possibly thus undermine the dignity and prestige of its own graduates of medicine. Therefore be it

RESOLVED, That The Council be instructed to ascertain from the administration of the University Hospital the facts concerning his question and if as reported to urge the cessation of such practices.

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

We shall go on then to the reports of the Reference Committee on Resolutions and we will not have time to finish that. However, we will work to approximately one o'clock.

Dr. Brasie of Genesee.

XIII. REPORT OF REFERENCE COMMITTEE

XIII-6. ON RESOLUTIONS

DR. BRASIE: Your Reference Committee on Resolutions met last evening with all members present.

We ask the privilege of the Chair to present some of these resolutions to you slightly differently inasmuch as there is quite a bit to do and there were a great number of men up for membership emeritus and otherwise. With your permission, sir, if there is no complaint from the floor, we will present them as a group.

THE SPEAKER: Is that agreeable to the House? (Agreed.)

XIII-6 (a). SPECIAL MEMBERSHIPS

DR. BRASIE: Your Reference Committee on Resolutions approved all the various resolutions presented re special memberships: briefly, to enumerate the names submitted:

Membership Emeritus: William A. Lathrop, M.D., E. C. Warren, M.D., Emil Amberg, M.D., William Kerr, M.D., Nancy Rodger Chenoweth, M.D., Henry G. Merz, M.D., G. F. Brewington, M.D., W. T. S. Gregg, M.D., David H. Burley, M.D., and Arthur Grigg, M.D.

Retired Members: Paul Roth, M.D., George M. Livingston, M.D., Bertha Moshier, M.D., J. Holes, M.D., and V. L. Tupper, M.D.

Affiliate Fellowship in A.M.A.: V. L. Tupper, M.D. Mr. Speaker, I move the adoption and acceptance of this portion of the report.

J. J. O'MEARA (Jackson): I second it.

THE SPEAKER: Is there any discussion? If not, all in favor say "aye"; opposed? The motion is carried. I would like to interrupt you for one minute. Dr.

Moore, the Chairman of the Council, has appointed a committee as follows: He has not named the chairman so I imagine he means the first name to be that of the chairman. These are the members of the Council who will be on the Council Committee to meet with the fact-finding committee just appointed by the Speaker. C. E. Umphrey, M.D., A. H. Miller, M.D., O. O. Beck, M.D., R. S. Morrish, M.D.; Wm. Barstow, M.D., L. F. Foster, M.D., as Secretary.

Now, Dr. Brasie.

DR. BRASIE: On the resolution concerning the centenary of anesthesia, the Committee deleted the name of Dr. Horace Wells of Hartford, Connecticut, and changed the resolution slightly and we offer this as a substitute resolution. I will read it first in its original form. Resolution No. 27.

XIII-6 (b), ENDORSING CENTENARY OF NITROUS OXIDE ANESTHESIA

"WHEREAS, 1944 marks the centenary of the application of a practical method of anesthesia by nitrous oxide by Dr. Horace Wells of Hartford, Connecticut, therefore be it

"RESOLVED, That the House of Delegates of the Michigan State Medical Society commends and endorses the celebration during 1944 of the centenary of this application of nitrous oxide anesthesia by Dr. Horace Wells of Hartford, Connecticut.

There was considerable discussion and some comments as to the fact it was not completely agreed as to who really did first discover this and should take the credit for it. We wish to back up the Society of Anesthetists, and not wishing to have any controversy, we offer the changed resolution as follows:

"WHEREAS, 1944 marks the centenary of the application of a practical method of anesthesia by nitrous oxide, therefore be it

"RESOLVED, That the House of Delegates of the Michigan State Medical Society commends and endorses the celebration during 1944 of the centenary of this application of nitrous oxide anesthesia by the Michigan State Society of Anesthetists."

Mr. Speaker, I move the adoption and acceptance of this report.

F. G. BUESSER, M.D. (Wayne): I second it.

THE SPEAKER: Any discussion? All in favor say "aye"; opposed? Carried.

XIII-6 (c). SELECTIVE SERVICE FOR MEDICAL STUDENTS

DR. BRASIE: Resolution No. 15 submitted by Dr. Pino, and entitled "Selective Service for Medical Students."

"WHEREAS, a recent Selective Service ruling provides that there shall be no deferments for pre-medical and medical students not enrolled in medical schools by July 1, 1944.

"WHEREAS, This ruling will reduce entering classes in 1945 by about 30 per cent, thus drastically curtailing medical classes,

"WHEREAS, Many such pre-medical and medical students would necessarily be physically disqualified men or women,

"WHEREAS, It is obvious that the number qualified would be entirely inadequate to meet the needs of medical care in this country during the next decade,

"WHEREAS, Many young medical officers will be detained in the army and navy and air corps for some time following the war, thus adding to the deficit.

"WHEREAS, Appeal to the army and navy and President of the United States by the AMA have been unproductive of results, be it therefore

"RESOLVED, That an appeal be made directly to the members of Congress from Michigan by the Michigan State Medical Society urging these members of Congress to take cognizance of a situation that inevitably will reduce the numbers of doctors of medicine in the United States to the point where medical care will be reduced far below necessary standards required to maintain safety of health care not alone from the standpoint of contagion but in all other aspects of health, and be it further

"RESOLVED, That the office of the Society implement this resolution."

This resolution was approved as read.

Mr. Chairman, I move the acceptance and adoption of this resolution.

C. E. SIMPSON (Wayne): I second it.

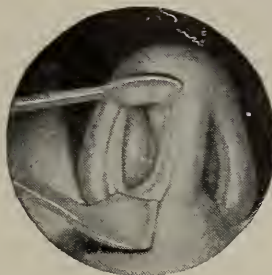
THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed? Carried.

(To be concluded in February issue)

A better means of nasal medication

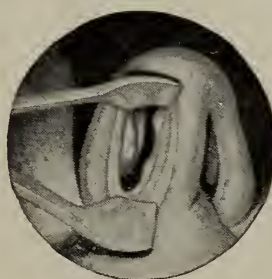
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Inferior and middle turbinates are highly engorged and in contact with the septum. The airway is completely blocked.



9 MINUTES AFTER TREATMENT

Maximum shrinkage has been obtained with 2 inhalations from Benzedrine Inhaler. The turbinates are contracted. The airway is open.



Butler and Ivy state that—for administering vasoconstrictive drugs—inhalers and sprays are preferable to nasal drops, and are—in most cases—“the better means of nasal medication,” because: (1) “. . . the drug reaches the nasal mucosa in more diffuse form . . .”; (2) “. . . the mucosa is never severely ischemic at any one point, but the effect is spread throughout the nasal cavity . . .”; (3) even when prolonged medication is required, there is “. . . far less pathologic change than that resulting from the use of nasal drops.”

Arch. Otolaryng., 39:109-123, 1944.



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WM. DE KLEINE, M.D., Commissioner, Lansing, Michigan

RECOMMENDATIONS FOR CONTROLLING SCALP RINGWORM

1. We advise health officers and school physicians to make a survey of all schools in communities where cases of scalp ringworm are known to exist.
2. The simplest way to make a clinical diagnosis is with the use of a Wood filter.
3. The best method of treatment known at the present time for the form of ringworm now existing in the state is epilation by means of x-ray and subsequent treatment with a suitable fungicide. Parents are warned that x-ray treatment of ringworm of the scalp may be dangerous unless given by a competent radiologist who is trained in this method of therapy.
4. All measures that are known or believed to prevent the spread of this infection should be introduced—sterilization of all instruments used in barber shops and beauty parlors; avoidance of the interchange of caps by children; disinfecting or otherwise treating the backs of theater seats; and other measures.
5. Exclude from school only children with massive scalp infections.
6. Children with minor or moderate infections may

remain in school, provided they are under competent medical care. We advise that all children while in school or other public places whether infected or not, wear caps made of cloth, paper or other material that can be burned or cleaned daily. Segregation of children with ringworm within the school may be an additional safeguard.

7. Parents and teachers should be informed as to the best procedures known, both for the prevention and treatment of ringworm infections.

8. Children who, for financial or other reasons do not consult a physician should be referred to a clinic in which facilities are provided for diagnosis and treatment.

MORE MEDICAL CARE PLANS

Iowa, Kansas, Missouri and New Hampshire recently approved the establishment of nonprofit plans for voluntary prepayment medical and surgical bills.

States in which medical plans previously were established are: Michigan, California, Colorado, North Carolina, Delaware, New Jersey, Pennsylvania, Massachusetts, and New York.

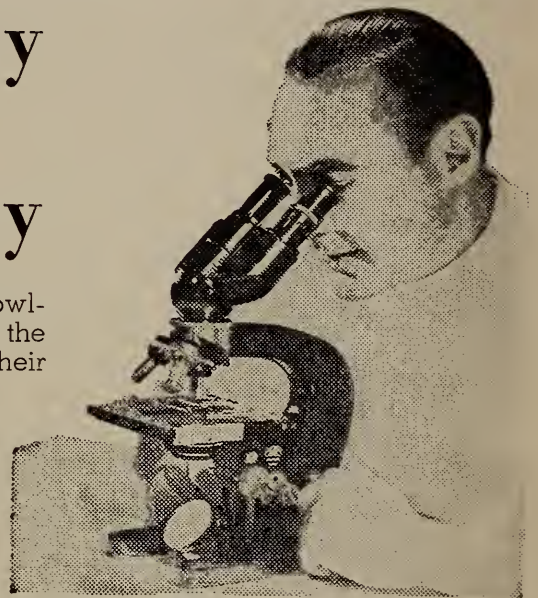
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Woman's Auxiliary

THE NEW YEAR

The beginning of the New Year is a time to glance briefly backward; then, to look ahead, chart a new course and go courageously forward. Our backward glance assures us that we have grown steadily through the years, have gained the strength of efficient organization and the confidence of our parent—the MSMS. Our forward glance sees the new problems ahead, the threat of legislation that may change the practice of medicine from a glorious profession to a political plaything.

Now is the time to use our strength, as an organization and as individuals, to fight this threat. Go forth, tell each and every American of the advantages he now has and would lose—the right to choose his own doctor, to change his doctor, to receive medical care when he wants it. Remind him that by joining Michigan Medical Service he will ease his financial burden even more than socialized medicine would. The taxation under the latter system would be greater than the cost of medical care to the average member of MMS.

Let every day see us doing something to further the cause of a free medicine and may the New Year bring the struggle to a glorious conclusion.

(Mrs. H. L.) LELA W. FRENCH
President

EXECUTIVE BOARD MEETS

The mid-year Executive Board Meeting of the Woman's Auxiliary to the Michigan State Medical Society was held Wednesday, November 29 at 12:30 P.M. at the Wayne County Medical Society Headquarters, Detroit. Twenty-eight were in attendance.

Mrs. H. L. French of Lansing, state president, presided at the meeting. Mrs. L. C. Harvie of Saginaw, president-elect and Mrs. French reported on the National mid-year meeting held in Chicago, November 16 and 17. Discussants included, Mrs. Guy Kiefer, honorary president, East Lansing and Mrs. John J. Walch, past president, Escanaba.

Mrs. T. Grover Amos, program chairman, had a very neat and compact kit for county presidents. Mrs. Amos is also the Auxiliary Convention Chairman for the Annual Session of September 19-20, 1945 at the Statler Hotel, Detroit.

Mrs. M. Shaw, radio speech contest chairman, stated that forty-eight schools from twenty-three counties had participated this year, five new counties entered.

Mrs. Roger Walker, Mrs. J. E. McIntyre, and Mrs. Oscar Stryker comprise the Nominating Committee.

The county presidents reported on their meetings so far and some reported plans for the whole year. Jackson County again sent Christmas boxes to thirty-eight doctors in service.

Kent County had a rummage sale and bridge tea, one outstanding meeting was a book review "Who

Walks Alone." They have found it very interesting to read letters from members away with their husbands who are in service.

Midland County had a rummage sale for benefit of hospital.

St. Clair County Auxiliary joined with the County Medical Society for dinner where approximately 300 outstanding leaders in the county heard Professor Floyd Armstrong give an address, "What Price Security."

Wayne County sent gifts to Percy Jones General Hospital. They are also having a Hobby Show with the doctors.

Mrs. Galen Ohmart, war service chairman, stressed the need for recruitment for Cadet Nurses.

Mrs. D. M. Kane, Hygeia chairman, suggested a plan for increasing subscriptions to Hygeia.

Mrs. Sherman Andrews, legislative chairman, has sent material to each county president; she would like a report from county legislative chairmen.

Mrs. W. L. Sherman, Wayne County Auxiliary president, made the arrangement for the luncheon at noon and also entertained the group after the board meeting at her home in the Art-Center Apartments.

* * *

Bay County

Mrs. J. Norris Asline entertained twenty-four members of the Medical Auxiliary at her home in Essexville, at a dessert meeting, with Mrs. C. L. Hess, president, presiding.

Mrs. Laura Dewey, executive secretary of the Bay County chapter of the American Red Cross spoke on "Returning Veterans—Physical, and Psychological Angles."

The rooms were decorated with bowls of yellow chrysanthemums. Hostesses were Mrs. P. R. Urmoston, Mrs. J. W. Gustin, Mrs. D. E. Siler, and Mrs. Robert Hall.

* * *

Wayne County

The Woman's Auxiliary to the Wayne County Medical Society had a very unusual program meeting on Friday, November 10. Luncheon at 12:30 was followed by the meeting at 2:00 P.M. The program was held in the Alger House and was a panel discussion on "Youth Problems in a Large City."

Mrs. Warren B. Cooksey acted as Moderator. Speakers included D. J. Healy, Judge of Probate, Juvenile Division, Wayne County; Miss Eleanore Hutzal, Chief of Woman's Division, Detroit Department of Police; Rev. Frederick Olert, First Presbyterian Church, and Prof. Earl Kelley, Wayne University.

The Ways and Means Committee sponsored a games party in the Auditorium of Providence Hospital on November 18.

A WOMAN'S PEACE OF MIND

No one understands the complexities of a woman's mind as well as her physician. He is fully aware that the menstrual period may often initiate temporary psychosomatic difficulties, or aggravate existing emotional maladjustments.

Today — with so many exacting demands upon women — any measure which contributes to her greater sense of comfort and well-being merits the physician's special attention.

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(1) West. J. Surg., Obst. & Gyn., 51:150, 1943; (2) Clin. Med. & Surg., 46:327, 1939; (3) Am. J. Obst. & Gyn., 46:259, 1943.

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In Memoriam

R. S. Buckland of Baraga was born September 28, 1866 in Paxton, Illinois and was graduated from the Fort Wayne Medical College in 1892. After graduation he located at Ewen. After practicing at Ewen and Trout Creek for eight years, he went to Baraga, where he served the community for forty-four years. During his early practice in the north country, Dr. Buckland experienced all the hardships legendary to "a country doctor"; in later years, he was recognized for his excellent results with bone injuries. He was on the staff of St. Joseph's Hospital, Hancock. Dr. Buckland not only rendered great service in his professional work but always took an active part in civic affairs and contributed generously to the growth and development of the Copper Country. He died Oct. 13, 1944.

* * *

Hugo Erichsen of Birmingham was born June 22, 1860 in Detroit and was graduated from the University of Vermont College of Medicine, and the Detroit Medical College. From the Royal College of Physicians and Surgeons of Kingston, Ontario, he received the degree of L.R.C.P. and S. in 1883 and later in life Wayne University conferred upon him the honorary degree of Doctor of Letters. From 1884 to 1886 he was professor of neurology in the medical department of Chaddock University, of Quincy, Illinois. In the course of his lengthy career he was assistant editor of the Detroit Clinic in 1882 and was City Physician from 1888 to 1890. From 1898 to 1918 he was on the editorial staff of Parke, Davis and Company; then director of Medical service for the Burroughs Adding Machine Company from 1918 until 1926. Doctor Erichsen retired to Birmingham where he continued his literary work until the time of his death, October 10, 1944.

* * *

Robert McGregor of Saginaw was born January 23, 1861, in Glasgow, Scotland, and was graduated from the University of Michigan medical school in 1894. He studied at the universities of Edinburgh, Glasgow and London before coming to America. Doctor McGregor was a neurologist and psychiatrist and in the early months of selective service served as a psychiatrist for the local draft board in Saginaw. Too old for active service in World War I, he returned to the British Isles voluntarily to serve in London hospitals. He was one of Saginaw's oldest practicing physicians. Doctor McGregor died after a brief illness October 31, 1944.

* * *

Rush McNair of Kalamazoo was born July 1, 1860, in Blackberry Station, Illinois and was graduated from Northwestern University Medical School in 1887. Following graduation he located in Kalamazoo. In 1889, Doctor McNair performed the first appendectomy in

(Continued on Page 94)

FIGHT INFANTILE PARALYSIS

This plea keynotes the great humanitarian struggle waged unceasingly by the National Foundation for Infantile Paralysis since its inception in 1938 . . . and climaxed each January by an intense public awareness and support campaign.

The vast scope of the battle against infantile paralysis — involving the time, skill and knowledge of our finest doctors and scientists — cannot be comprehended by the majority of people. However, so deep is the desire of Americans to see the obliteration of this dread disease, that they have to date contributed millions of dollars through annual March of Dimes appeals for research purposes alone.

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IN MEMORIAM

(Continued from Page 92)

Southwestern Michigan and perhaps in Michigan, when it was considered fatal to open the abdominal cavity. Medical men of that day held that with this feat he opened the field of abdominal surgery. In 1903 Doctor McNair studied surgery under some of the most noted medical men of that time in Edinburgh. In 1926 Doctor McNair was president of Kalamazoo Academy of Medicine. In later years he prepared and wrote with great enthusiasm his, "Medical Memoirs of Fifty Years in Kalamazoo"—a work which was valuable both as interesting reading and as a source of much historical and biographical information about this section of Michigan. He had recently reopened his offices in the McNair block to begin his fifty-eighth year of practice in Kalamazoo. He died after a brief illness, October 16, 1944.

* * *

James Mitchell of Gladstone was born February 10, 1870 in Kingston, Ontario and was graduated from Queen's University Faculty of Medicine in 1899. Going to Gladstone upon graduation, he remained there briefly and then removed to Saskatchewan, Canada. After a year in Saskatchewan, he returned to Gladstone and was engaged in the practice of medicine there since the turn of the century. Doctor Mitchell was not only one of the senior practitioners of medicine in Delta County, but in addition took an active part in his community activities. He served for thirteen years as a member of the Gladstone Board of Education, heading the body for a time as president. He had been city health officer since 1935. Doctor Mitchell died after a week's illness, October 20, 1944.

* * *

Alexander L. Turner of Detroit was born July 25, 1883 in Eatonton, Georgia and was graduated from the University of Michigan medical school in 1905. He served his internship at Freedman's Hospital in Washington, D. C. and immediately began his practice in Detroit. Later he became a member of the staffs of Women's Hospital and Grace Hospital. He was one of the founders and organizers of the Dunbar Memorial Hospital and an active worker in the building of the St. Antoine Branch YMCA. He died at Ravenna, Ohio, on August 12, 1944.

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What's What

Personals

George J. Curry, M.D., Flint, presented a paper on "Principles in Management of Simple and Compound Finger Fractures—Amputations" at the annual post-graduate course in Industrial Medicine and Surgery, held at Long Island College of Medicine, Brooklyn, in October.

* * *

The weekly staff conference at Percy Jones General and Convalescent Hospital, Battle Creek, during December, included: December 4—"Some Aspects of Chemotherapy" by Gordon B. Myers, M.D., Detroit; December 11—"Acute Suppurations of the Mouth, Throat and Neck" by A. C. Furstenberg, M.D., Ann Arbor; December 18—"Symposium on Convulsive Disorders" by Major I. L. Turow, Major Frank H. Mayfield and Lt. D. B. Foster.

The January talks were as follows: January 8—"Urology in General Practice" by Edward M. Cook, M.D., Rochester, Minn.; January 15—"Newer Approaches in the Field of Hematology" by Major Sylvan E. Moolten, Captain W. E. Peltzer, and Miss Edna Keller, Battle Creek; January 22—"Skeletal Traction

with Crutchfield Tongs for Spinal Injuries" by W. Gayle Crutchfield, M.D., Charlottesville, Va.; January 29—"Discussion of Pituitary Pathology" by Major G. R. Joyner, Assistant Chief of Medical Service, Battle Creek.

* * *

F. L. Rector, M.D., Lansing, Cancer Consultant of the Michigan State Medical Society and the Michigan Department of Health, gave the principal address at the annual meeting of the Cleveland and Cuyahoga County, Ohio, Field Army Against Cancer on December 5. His subject was "The Why, What and How of Cancer Control."

* * *

Clarence H. Snyder, M.D., Grand Rapids, represented the Michigan State Medical Society on the Physical Rehabilitation Panel arranged on the occasion of the Annual Meeting of the Michigan Society for Crippled Children and Disabled Adults, Grand Rapids, November 17.

* * *

Secretary L. Fernald Foster, M.D., Bay City, was guest speaker at the North Central Medical Conference, (Continued on Page 98)

3

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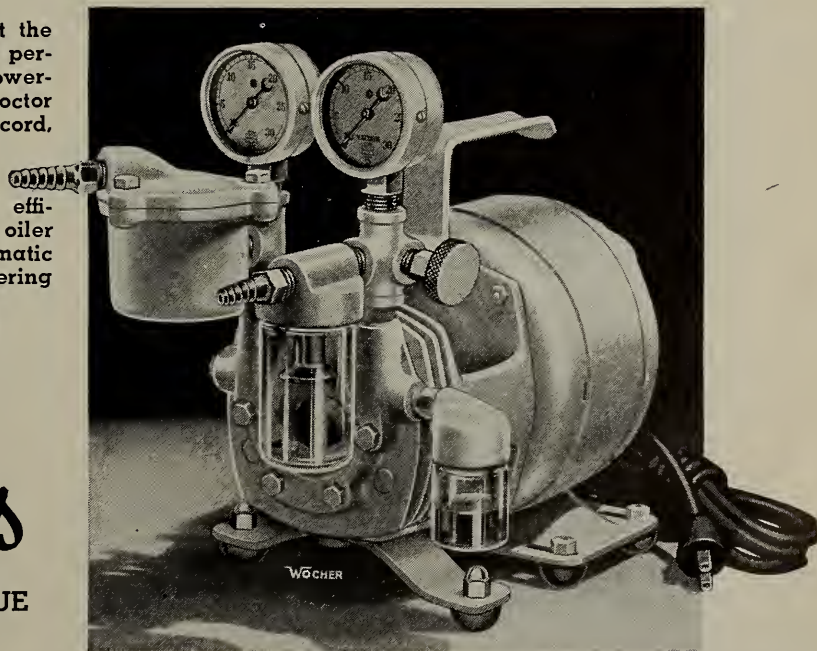
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Saint Paul, December 10. His subject was "Prepay Medical Service," and included a report on Michigan Medical Service.

* * *

A. B. Gwinn, M.D., Hastings, Michigan, had an article published in the *American Journal of Surgery*, entitled "Gas Gangrene Treated with Sulfathiazole and Zinc Peroxide," pages 430 to 433, September, 1944. The article is illustrated with several radiographs of hands showing the involvement and treatment.

* * *

Honors

D. J. McColl, M.D. of Port Huron was honored by the Port Huron Kiwanis Club for his fifty-one years of practice as a physician in Port Huron and twenty-five years of service with the Kiwanis Club. Kiwanis presented Dr. McColl with a certificate of life membership for distinguished service to Kiwanis and to his community. Congratulations Dr. McColl!

* * *

Michigan Physician Army Officers who have been promoted from Major to Lieutenant Colonel include the following: John Merton Schonfeld, Bloomfield; G. Howard Gowan, Ann Arbor; Theodore Henry Pauli, Pontiac; Leslie Frank Wilcox, Grosse Point Farms; Clifford Wesley Colwell, Flint.

* * *

Captain Mark W. Dick, MC, of Grand Rapids, has received the bronze star for bravery under fire. His citation declares that "on March 12, 1944, at Bougainville, Solomon Islands, while enemy mortar shells exploded around him, he ran 40 yards and crawled under a barbed wire entanglement to reach a seriously wounded soldier. Finding that the nature of the man's wounds made it impossible to move him to the protection of a pillbox, he unhesitatingly exposed himself and stood in an upright position to administer medical treatment during the intense mortar barrage."

* * *

The American College of Surgeons announces that the following Michigan physicians were accepted into Fellowship of the ACS in 1944: John H. Albers, M.D., Detroit; Ralph M. Burke, M.D., Port Huron; Fleming A. Barbour, M.D., Flint; Matthew C. Bennett, M.D., Detroit; Robert W. Buxton, M.D., Ann Arbor; George E. Chittenden, M.D., Detroit; Clinton L. Compere, M.D., Grand Rapids; Peter Crabtree, M.D., Ann Arbor; Robert T. Crowley, M.D., Detroit; Fillmore S. Curry, M.D., Detroit; David M. Davidow, M.D., Detroit; A. Edward Drexel, M.D., Detroit; Paul W. DuBois, M.D., Detroit; Owen C. Foster, M.D., Detroit; Joe H. Gardner, M.D., Detroit; James L. Gillard, M.D., Muskegon; Cameron Haight, M.D., Ann Arbor; John E. Hauser, M.D., Detroit; Willet J. Herrington, M.D., Bad Axe; Moses J. Holdsworth, M.D., Grand Rapids; Benjamin F. Hoopes, M.D., Detroit; Reader J. Hubbell, M.D., Kalamazoo; Donald J. Jaffar, M.D., Detroit; Harry N. Jurow, M.D., Detroit; Earl B.

(Continued on Page 100)

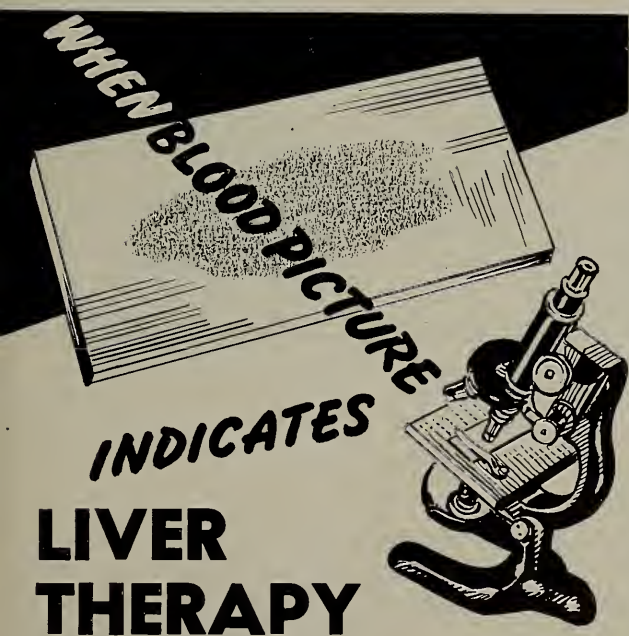
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* * *

AMA Session Cancelled

The American Medical Association will not hold its Annual Meeting in 1945, according to word received in January from Olin West, M.D., Secretary.

* * *

Coming Meetings

Doctor, you are cordially invited to attend the Annual Clinical Conference of the Chicago Medical Society, Palmer House, Chicago, February 27-28 and March 1, 1945. The program will be of interest to all physicians, general practitioners and specialists alike.

This Conference represents an opportunity for three days of intensive postgraduate medical education. Hotel reservations should be made at once.

* * *

Mt. Carmel Mercy Hospital will hold its Annual Clinic Day on Wednesday, January 31. Outstanding speakers will be on this program. A complimentary luncheon will be served all registrants in the Hospital at 1:00 p.m.

All members of the Michigan State Medical Society are cordially invited to attend this Clinic Day at Mt. Carmel Mercy Hospital, located at 6071 W. Outer Drive, Detroit.

* * *

Statistics

Michigan Medical Service.—Of each dollar received by Michigan Medical Service, 79 per cent goes to physicians for services, 12% for administration, and 9% into the reserve fund.

* * *

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* * *

The postwar reserve fund of the State of Michigan has reached \$47,000,000, and may be increased to \$50,000,000 before the end of the year.

(Continued on Page 102)

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If you change your address please notify THE JOURNAL promptly. The deadline for address changes for each issue is the 10th day of the month preceding date of publication, i. e., 10th day of January for the February issue. If you move, therefore the only way to be sure of getting your JOURNAL regularly is to send your new address in immediately.

If your JOURNAL is late in reaching you these days, please be patient. The mails are clogged and there is a shortage of labor at our print shop. Wait until the 20th of the month before assuming your JOURNAL has gone astray. If you don't get it by then, drop us a line and we will mail you a copy, if extra copies are available.

Incidentally the State Treasury has retired the last of the \$50,000,000 bond issued twenty years ago to launch the construction of modern automobile highways in Michigan.

* * *

\$34,000 in war bonds as prizes will be given for the best art works of physicians, memorializing the medical profession's "Courage and Devotion Beyond the Call of Duty," in war and in peace. This prize contest is open to any physician member of the American Physicians Art Association. For further information write Mead Johnson & Co., Evansville, Indiana.

* * *

Civilian enrollment at the fifty-six Michigan colleges and university has declined one-third during the war period, from 67,220 in 1941 to 47,427.

* * *

The Michigan Civil Service Commission reported that state salaries average \$182.50 a month today, compared to an average of \$126.92 a month in 1941. If 1944 wages were paid to the 1941 number of workers, the cost would be \$10,000,000 more than it actually was in 1941. There are 3,733 less employees now than in 1941.

* * *

Wayne University of Detroit has submitted a request for state aid to the Michigan Planning Commission, pointing out that it has become a large institution of general service to Michigan. The Wayne memorandum states that almost as many physicians practicing in Michigan are graduates of Wayne as are graduates of the University of Michigan School of Medicine.

* * *

A total of 83,544 babies were born in Michigan during the first nine months of 1944.

* * *

Good Reading

Recommended for physicians' reading: "Economic Liberalism and Free Enterprise" by Benjamin L. Masse,

(Continued on Page 104)

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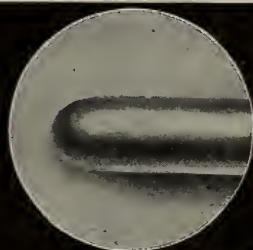
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* * *

"Principles of a Nationwide Health Program." This editorial which appeared in JAMA of November 4, 1944, Page 640, is an article that should be read by every member of the Michigan medical profession.

* * *

Miscellaneous

Information on the so-called "Academy-International of Medicine and Dentistry," of 509 Minnesota Street, Saint Paul, Minnesota, may be obtained by contacting the Michigan State Medical Society, 2020 Olds Tower, Lansing 8.

* * *

County Medical Society Elections

The following Adrian physicians were recently elected as officers of the *Lenawee County Medical Society*:

President: Esli T. Morden, M.D.

Secretary: Thomas H. Blair, M.D.

Vice President: Leo J. Stafford, M.D.

Delegate: Esli T. Morden, M.D.

Alternate: Thomas H. Blair, M.D.

* * *

At the November meeting of the *Jackson County Medical Society* the following were elected as officers:

President: E. A. Thayer, M.D., Jackson

President-Elect: Frank Van Schoick, M. D., Jackson

Secretary: H. W. Porter, M.D., Jackson

Delegates: J. J. O'Meara, M.D., Jackson and Corwin S. Clarke, M.D., Jackson

Alternate Delegates: C. R. Dengler, M.D., Jackson and J. D. Van Schoick, M.D., Hanover

* * *

New officers of the *Clinton County Medical Society* elected at the December meeting of the County Society are:

President: B. R. Elliott, M.D., Ovid

Vice President: C. T. Foo, M.D., St. Johns

Secretary-Treasurer: T. Y. Ho, M.D., St. Johns

Delegate: W. B. McWilliams, M.D., Maple Rapids

Alternate: A. C. Henthorn, M.D., St. Johns

CORRESPONDENCE

December 5, 1944

L. Fernald Foster, M.D.
Secretary the
Michigan State Medical Society
2020 Olds Tower
Lansing, Michigan
Dear Doctor Foster:

Your kind communication informing me of my election to Emeritus Membership in the State Society has touched me deeply.

I only tried to do my duty as I saw it.

May I express to the Society my cordial thanks for the high honor of which I am very conscious, and for the good wishes extended to me. It is a great satisfaction to learn that one is understood during one's lifetime.

Most sincerely yours,

(Signed) EMIL AMBERG
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TRICHINOSIS. By Sylvester E. Gould, M.D., D.Sc., Pathologist and Director of Laboratories, Eloise Hospital, Eloise, Michigan; Assistant Professor of Pathology, Wayne University College of Medicine, Detroit. Springfield, Ill.: Charles C. Thomas, 1945. Price \$5.00.

One of our Michigan doctors has given us a valuable monograph on trichinosis. He discusses the history of trichina, the discovery by various ones and the increasing knowledge of the disease. The morphology and life cycle of the parasite is given, the epidemiology and pathology of the disease. Laboratory methods of study are given in detail, also a discussion of the symptomatology and treatment. The treatment is non-specific, and the mortality varying from zero in two epidemics involving 200 cases to one of 30 per cent of 337 cases. The average is around 10 per cent. This is an authoritative text, full of material, with a bibliography beginning with Tiedemann in 1822, and ending with many citations in late years. The practicing physician, the public health worker, the laboratory man must have this work to understand the increasing numbers of persons infected with this disease.

PENICILLIN-C.S.C.

For administration in the physician's office or in the patient's home, Penicillin-C.S.C. will be available in a convenient combination package, as soon as the drug is released for unrestricted use in civilian practice. This combination package provides two rubber-stoppered, serum-type vials. One vial contains enough physiologic salt solution to permit the withdrawal of 20 cubic centimeters. The other vial contains 100,000 Oxford Units of penicillin sodium or penicillin calcium* respectively.

The physiologic salt solution is sterile and free from fever-producing pyrogens. Penicillin-C.S.C.—whether the sodium salt or the calcium salt—is bacteriologically and biologically assayed to be of stated potency, sterile, and free from all toxic substances, including pyrogens, as attested by the control number on the package.

When 20 cc. of the physiologic salt solution is withdrawn from its vial, and injected into the penicillin-containing vial under the usual aseptic precautions, the resultant solution presents a concentration of 5000 Oxford Units per cubic centimeter. The solution is then ready for injection, does not require resterilization.

After the desired amount of the solution for the first injection has been withdrawn, the vial containing the remainder of the solution should be stored in the refrigerator. It is ready for the next injection—the desired amount then merely has to be withdrawn under proper sterile technic.

When released for unrestricted marketing, Penicillin-C.S.C. will be stocked throughout the United States by a large number of selected wholesalers. Any pharmacist thus will be able to fill professional orders promptly.

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*Penicillin calcium, equal to penicillin sodium in therapeutic efficacy and nontoxicity, in recent investigations has been shown to be less hygroscopic than the sodium salt, and somewhat more stable. Both forms of the drug should be stored in the refrigerator, at a temperature not over 50° F. (10° C.).

Therapeutic Reference Table . . . Penicillin-C.S.C.

CONDITIONS IN WHICH PENICILLIN IS THE BEST THERAPEUTIC AGENT AVAILABLE

CONDITION	MODE OF ADMINISTRATION	DOSE*	DURATION AND COLLATERAL THERAPY
1. All staphylococcal infections with and without bacteremia:			
• Acute Osteomyelitis	Intramuscular or Intravenous and Local	10,000 to 15,000 O.U. every 4 hours	7 days or less, debridement and surgery as required
• Chronic Osteomyelitis	Intramuscular or Intravenous and Local	250 to 500 O.U. per 6c. NaCl solution 20,000 O.U. every 4 hours	
• Carbuncles, Soft Tissue Abscesses	Intramuscular or Intravenous	250 to 500 O.U. per 6c. NaCl solution	According to response; debridement and surgery as required
• Chronic Abscess Formation	Intramuscular or Intravenous	10,000 to 15,000 O.U. every 4 hours	7 days or less
		20,000 O.U. every 4	According to response
2. All hemolytic streptococcal infections			
• Cellulitis			
• Mastoiditis			
• Abscesses with intracranial complications (meningitis, abscess, thrombosis, etc.)			

A page of the "Penicillin-C.S.C. Therapeutic Reference Table," showing recommended dosages and modes of administration; a copy is yours for the asking.

You and Your Business

THE "COMMITTEE OF 29"

Michael M. Davis, Ph.D., Chairman of the Committee on Research in Medical Economics, New York, and twenty-eight other sponsors identifying themselves as the "Health Program Conference" presented a detailed program for compulsory political medicine at a meeting on December 4 in New York City.

Mr. Davis acted as Conference Chairman and, according to the *New York Times*, "announced that members of the Conference are not putting forth their report as a bill for Congressional action; instead they are offering basic principles which could serve as a framework for improving health legislation and for action by nongovernmental bodies." The program "would insure good medical and hospital facilities to every man, woman and child in this country, regardless of ability to pay."

It is interesting to note that the program would put an end to Blue Cross Hospital Plans and all voluntary pre-pay medical care plans!

Members of the Health Program Conference included Will W. Alexander, Chicago, vice president Julius Rosenwald Fund; E. W. Bakke, New Haven, Economics Professor, Yale University; Solomon F. Bloom, New York, former associate secretary, American Association for Social Security; Dr. Ernest P. Boas, New York, Chairman, Physicians Forum; J. Douglas Brown, Princeton, Economics Professor, Princeton, University and Consultant to the Secretary of War; Dr. Allan M. Butler, Boston, Harvard Medical School and Chief of Children's Medical Service, Massachusetts General Hospital; Dr. Hugh Cabot, Boston, Committee of Physicians for the Improvement of Medical Care; Dr. Dean A. Clark, Washington, United States Public Health Service; Michael M. Davis, Ph.D., New York, chairman, Committee on Research in Medical Economics; I. S. Falk, Washington, Social Security Board; Dr. Nathaniel W. Faxon, Boston, director of Massachusetts General Hospital, and Dr. Channing Frothingham, Boston, chairman, Committee of Physicians for the Improvement of Medical Care.

Dr. Franz Goldmann, New Haven, Yale School of Medicine; Herman A. Gray, New York, attorney and chairman, New York State Unemployment Insurance Advisory Council; Dr. Alan Gregg, New York, director of Division of Medical Sciences, Rockefeller Foundation; William Haber, Ann Arbor, Economics Professor, University of Michigan, now with the War Manpower Commission; Dr. Basil C. MacLean, Roch-

ester, director, Strong Memorial Hospital; Gerald Morgan, Hyde Park, Social Security Board consultant; Dr. Frederick D. Mott, Washington, chief medical officer, Farm Security Administration; George St. J. Perrott, Washington, United States Public Health Service; Dr. John P. Peters, New Haven, Professor of Medicine, Yale University; Kenneth E. Pohlmann, Arlington, Va. Farm Security Administration; Dr. Kingsley Roberts, New York, director, Medical Administration Service; Barkev S. Sanders, Washington, Social Security Board; Dr. Gertrude Sturges, Wakefield, R. I., consultant, American Public Welfare Association; Florence C. Thorne, Washington, research director, American Federation of Labor; J. Raymond Walsh, Washington, research director, Congress of Industrial Organizations; C. E. A. Winslow, New Haven, Professor of Public Health, Yale University, and Edwin E. Witte, Madison, Wis., Economics Professor, University of Wisconsin and member National War Labor Board.

* * *

VIGOROUS COUNTER OFFENSIVE

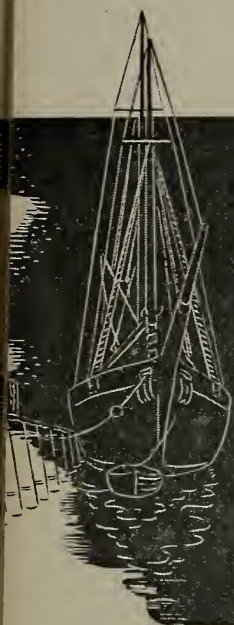
The Bulletin of the Genesee County Medical Society, Jan. 9, 1945, issue, contains an editorial by A. C. Pfeifer, M.D., entitled "'The Road to Hell is Paved with Good Intentions'—Karl Marx." The editorial refers to recent federal and proposed state attempts to regiment the medical profession and institute compulsory political programs of medical care.

The last paragraph of this excellent editorial states:

"The medical profession of this State is up against a war of extermination so far as private practice is concerned. If our plan of defense consists of defense only, it is only a matter of time until we must wave the white flag and accept the only terms that are offered us. Our only salvation lies in a vigorous counter-offensive which will ally to our common cause the majority of the votes of our people.

The only counter attack that can succeed is a sound plan sponsored and managed by the medical profession that will be acceptable to the people. This plan obviously must be a service, State-wide in scope, of prepaid medical, surgical and hospital ministrations. It must be the kind of service outside of government control that the people are desiring and will demand. It's time to wake up, Doctor!"

(Continued on Page 120)



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despite the
shortages
of war



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MICHIGAN HOSPITALS TO BE SURVEYED •

The Michigan Commission on Hospital Care approved a detailed survey of hospital services at its December 15 meeting in Lansing. The study will be supervised by Arthur C. Bachmeyer, M.D., Chicago, National Director of the National Commission on Hospital Care.

The objectives are:

1. Survey of present hospital and public health department facilities.
2. Determination of the need for additional facilities.
3. Draft of a state hospital plan (including a long-range program for a system of co-ordinated and integrated hospital and public health department facilities).
4. Establishment of the means for administration and supervision of a co-ordinated hospital plan through an official body appointed to represent hospitals, professions and the public through the enactment of a state hospital licensure law to guide hospital development and to maintain proper standards of hospital service.

The Michigan Commission on Hospital Care also approved a proposed hospital licensing bill for submission to the 1945 Michigan Legislature. This proposal will provide for the regulation of hospitals, sanitariums, rest homes, nursing homes, and related institutions, and for the granting, suspending and revoking of licenses. It would be administered by the Michigan Department of Health, aided by an advisory board of seven members.

A. S. Brunk, M.D., President of the Michigan State Medical Society, is a member of the Michigan Commission on Hospital Care as well as a member of its Executive Committee.

* * *

MICHIGAN MEDICAL SERVICE

Despite adverse reports of the condition and stability of Michigan Medical Service that have been published in *Fortune* and other reports the service has paid to Doctors for services up to December 31, 1944, \$9,485,285.12. It has paid out for medical services \$1,215,177.25 in the past four months. There were 768,755 persons protected. Incidentally, the family certificate is 4.20 persons. The deficit at the beginning of the year of \$186,000 has been turned into a surplus of \$194,016.77. In addition the proration of \$128,666.29 has been paid and reserves set up for the MSMS and MHS loans.

* * *

EMERGENCY MATERNITY AND INFANT CARE

For servicemen's wives and new babies, the federal government has spent *over a million and a half dollars in Michigan* during the first eleven months of 1944 according to the Michigan Department of Health which administers this Emer-

gency Maternity and Infant Care Program Available for wives and infants of servicemen in the four lowest pay grades, this service provides hospital, medical and nursing care for maternity cases and for infants under one year of age.

Since the project started in Michigan in May 1943, the State Health Department has approved maternity care for 22,537 soldiers' wives and medical and hospital care for 2,114 infants. The percentage of applications for infant care is increasing since the program was expanded to include immunizing infants against smallpox, diphtheria and whooping cough.

For maternity cases the government pays doctors for supervising care during the entire period of pregnancy, for delivery and the examination six weeks after the baby is born. It also pays the hospital for the ten-day period that mother and baby spend there.

* * *

CONTRIBUTIONS TO THE MSMS FOUNDATION

"I am still hoping that other doctors of medicine will follow suit and contribute even small amounts to the Michigan State Medical Society Foundation for Postgraduate Medical Education," writes a Michigan practitioner of medicine who recently contributed his second annual contribution to the MSMS Foundation for Postgraduate Medical Education. This generous donor, who requests that he remain anonymous, has indicated that he will contribute a substantial sum yearly to the Foundation. It is hoped that his example will be followed by many other members of the Michigan State Medical Society who may be in a position to give financial assistance for continuing medical education.

* * *

AMERICAN COLLEGE OF SURGEONS ANNOUNCES 1944 APPROVED LIST OF HOSPITALS

The American College of Surgeons announces that 3,152 hospitals in the United States and Canada are included in the 1944 Approved List. The list is published in the annual Approval Number of the College Bulletin issued December 31.

A total of 3,911 hospitals were included in the 1944 survey and the approved hospitals represent 80.6 per cent. The first annual survey in 1918 included 692 hospitals of 100 beds or over of which only eighty-nine (12.8 per cent) merited approval. Hospitals of twenty-five beds and over are covered in the current surveys.

A total of 2,342 hospitals of 100 beds and over were on the 1944 survey list, and 2,182 (93.1 per cent) were approved. A total of 1,119 hospitals of fifty- to ninety-nine-bed capacity were under survey, of which 789 (70.3 per cent) were ap-

(Continued on Page 122)

"TOO LITTLE and TOO LATE"

"TOO LITTLE and too late" can be as disastrous in therapy as in warfare. This, it is now realized, is especially true in nutritive failure, where frequently it is too much to expect that a balanced diet alone will not only supply the patient's daily requirements but will also be able to compensate for deficiencies of long standing.

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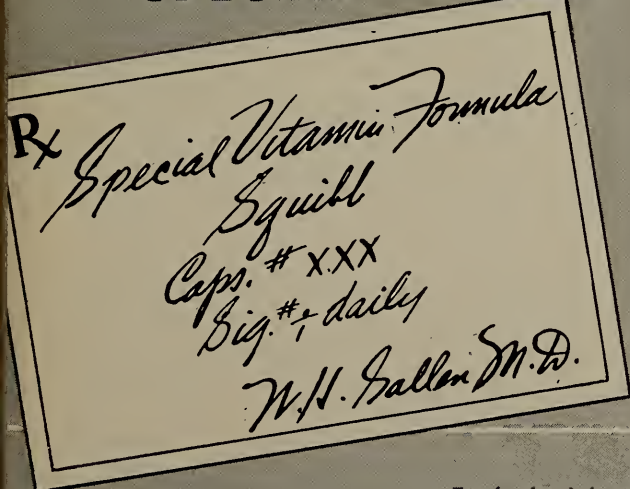
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ciencies it offers you a convenient and economical means of providing a dietary supplement of high potency and balanced formula.

Special Vitamin Formula is a non-proprietary name, easy to remember. You may prescribe as many or as few of these capsules as you consider desirable without affecting the low cost to the patient—only 5¢ to 6¢ per capsule—since they are supplied to druggists in bulk. Be sure to specify . . .



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(Continued from Page 120)



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proved. A total of 450 hospitals of twenty-five to forty-nine-bed capacity were under survey, of which 181 (40.2 per cent) were approved.

On December 31 of each year the ratings of hospitals under survey by the American College of Surgeons automatically terminate. The status of every hospital based upon all data collected from the current survey is reconsidered each year.

BOARD APPROVES GIFTS TO WAYNE

Gifts to Wayne University accepted by the Board of Education include a grant of \$1,500 from Frederick Stearns and Company to be used in the study of amino acids, it was announced by Dr. David D. Henry, executive vice president of the University. The research project will be directed by Dr. William M. Cahill, assistant professor of physiological chemistry at the College of Medicine.

Other gifts accepted include the sum of \$1,000 contributed by Dr. James Milton Robb for the use of the Alpha Omega Alpha Scholarship and Lectureship Foundation at the College of Medicine, and the sum of \$100 from the American Foundation for Pharmaceutical Education, to be used as a scholarship fund at the College of Pharmacy.

GOVERNOR KELLY'S INAUGURAL TO LEGISLATURE

Governor Harry F. Kelly addressed the Michigan Medical Legislature on January 4, 1945. Interesting extracts include:

"Mental health has been a major problem for many years, has increased in importance in these troubled war years, and will assume even greater proportions in the postwar world. The terrific strain of combat on the battle fronts and the stress of wartime living conditions at home are already creating a situation which demands our immediate attention. . . . The anticipated mental load in the coming two years is so large that further hospital expansion will be required at the earliest possible date. As of today there are more than 25,000 mental patients in the hospitals of the state. . . . The total cost of all phases of the mental health program is approaching \$15,000,000 a year."

Governor Kelly recommended the building of additional hospital facilities for the insane, feeble-minded and epileptic, as well as the reorganization of the Hospital Commission as an advisory group to a newly created Director who would have the sole responsibility for administration of the mental health program.

Governor Kelly also recommended consolidation of all public health inspections in the State Health Department with such inspections to be carried out so far as possible by the counties and district health units.

The JOURNAL

of the Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOLUME 44

FEBRUARY, 1945

NUMBER 2

Tubovalvular Gastrostomy

History and Technique

(Determining Credit for Origination in Surgery)

By Max Thorek, M.D.
Chicago, Illinois



Professor of Surgery, Cook County Graduate School of Medicine; Attending Surgeon, Cook County Hospital; Surgeon-in-Chief, American Hospital of Chicago; General Secretary International College of Surgeons; et cetera.

■ To some individuals, untrained in the ways of scientific progress and proper professional methods of procedure, the controversies, often long continued, as to who should have the credit for the establishment of a scientific fact or a new procedure seems trifling and a matter of minor importance. On the other hand, sincere professional workers consider the immediate recording of scientific discoveries and technical advances vital to progress. Of equal importance is the maintaining of an unswerving professional honesty in recognizing priority of claims for origination of ideas and technique, and giving credit where credit belongs. The full acknowledgment by any professional man of the work of others who have preceded him, or who are contemporary contributors to the development of important methods and procedures, is one of the most valuable signs

of the appreciation of such terms as "literary honesty," and "dependability in recording." Only by such conduct in scientific matters can the literary torchlight of truth be kept aloft.

Certainly, the zealous coveting of proper recognition by scientific workers, is the very life of scientific progress. Further than this, the prompt acknowledgment of our indebtedness to the work of scientists of other countries is the very essence of mutual respect, international scientific advancement, the very keynote for fostering better international understanding and good will.

Medical historians cannot be careless or vague in the matter of affixing credit due, but must ever sift and resift the facts and evaluate claims of scientists dead or alive with fairness and without the faintest tinge of prejudice for or against, if worthwhile precepts are to be kept before the new generations of scientific workers.

It is with these thoughts in mind that we briefly review the history of development of one of the oldest surgical operations in the abdomen—gastrostomy—particularly *tubovalvular gastrostomy*.

In 1931, I published an article in Paris, France, in which I described a method of tubovalvular gastrostomy¹² which was attributed to Spivack. For a time, I continued to refer to the operation as the Spivack method.

Following my publication of this article in Paris, France, French colleagues began to make themselves heard in protest against my attributing credit to Spivack, pointing out that the working out of a tube from the stomach wall in gastrostomy had been done by Dépage³ of Belgium (1903)¹, and by Janeway⁷ in the United States (1913) long before Spivack. Furthermore, it was pointed out to me that the formation of a valve

Read at the Mt. Carmel Mercy Hospital Staff Clinic Day, January 31, 1945.

from the stomach wall had been worked out and recorded by Pelière of Toulouse and Pénieres in 1893, and perfected by Fontan in 1896. In fact, the latter procedure has been spoken of for years as the "Fontan valve" or the "Fontan operation."

Regrettably, I had not checked the literature before sending my first article to France, but being challenged, I had the late William F. Brennan, a competent and reliable research worker, make a complete search of the literature. I found that the complaints against my article in the French Journal were substantiated and fully justified.

It was found that the scientists mentioned above preceded Spivack by from sixteen to thirty-five years! I also found that Spivack had published an article in 1929 in which he had included in his bibliography an abstract of an article by Fontan, showing that he was aware of the contribution that Fontan had made, but the name Spivack gave in his bibliography was *Fontana* (sic) instead of Fontan, and the only reference he gave was a brief abstract (only two paragraphs) which appeared in the *Semaine Medical* (p. 421, October 21, 1896), while the principal, full and illuminating article of Fontan which appeared *in extenso* under the title of "Une nouvelle opération de gastrostomie (procédé valvulaire), (*Assoc. franc. de chir. Proc. verb. Paris, 10:411-415, 1896*) was not mentioned by Spivack at all.

As soon as I had discovered the merits of the claims for priority of the French, American and other earlier surgeons to recognition for this work in gastrostomy, I chose the positive course of action rather than the unpleasant method of negation. In all later statements in my teaching or writing, I endeavored to rectify my mistake by giving full credit to those scientists dead or alive. For a time it was thought that Spivack had, at least, the originality for combining two methods, but even this step was found to have already been done and recorded by an earlier surgeon, *Watsudji*, thirty years before Spivack! To set forth briefly and with exactitude the historical development of the operation of tubovalvular gastrostomy, and to clear the record, I present the following facts and illustrations from the original articles as they appear in the literature.

What is tubovalvular gastrostomy?

Tubovalvular gastrostomy is a gastrostomy

formed of a tube and a valve both made from the stomach wall.

Who constructed the valve?

Let the record speak.

A. Valve Was Formed of Mucosa by L. Pénieres in 1893⁸

We see that Pénieres wrote (Fig. 1):

A valve composed of mucous membrane fulfils its intended functions when it prevents the escape of gastric juice. This has been accomplished, for in our cases there has been neither inflammation nor ulceration of the skin, which, indeed, proves our contentions that the gastric juice remained in the stomach and was not able to excoriate or injure the skin.

Observe the picture of the valve.

Furthermore, it may be mentioned here that our own Edmund Andrews and Wyllys Andrews of Northwestern University, Chicago, as far back as 1894 conducted experiments and contributed an article on "*A new method of valvular gastrostomy with a mucous membrane lining*"¹, in which they say:

"A female dog weighing forty-five pounds was subjected to this operation April 5, 1894. There was no leakage of the contents of the stomach whatsoever, at the end of a month, she was in robust health and on being killed May 4, the valve in the stomach was found in good working order."

Spivack did not give a line of credit to these men.

B. Valve Was Formed of All Layers of the Stomach by Fontan in 1896⁵

Fontan formed a valve in the stomach from all layers of its walls, the mucosal being the inner surface of the valve. Fontan acknowledges his indebtedness to Pelière of Toulouse who produced, in the experimental laboratory, valves of the mucous membrane alone. Says Fontan (Figs. 2 and 3):

I have conceived the idea of performing a valvular operation—modifying it from an organic and surgical point of view. In my operation all layers of the stomach form the valve and not the mucosa alone; secondly, I make the valve in one sitting in a very simple manner. . . . I can affirm absolutely that no gastric juices escape following this operation.

Note that the date when the valve of Fontan was made from all layers of the stomach is 1896—thirty-three years before Spivack.

Archives Provinciales de Chirurgie

Vol. II, No. 4, April 1893

De la Gastrostomie par la méthode de la valvule ou du plissement de la muqueuse stomacale.

PAR

L. PÉNIÈRES (de Toulouse)

Chargé du cours de pathologie externe à la Faculté de Médecine.

La valvule muqueuse a rempli ses fonctions prévues en empêchant la sortie des liquides. Il n'y a eu au pourtour de l'orifice ni inflammation, ni ulcération de la peau, ce qui prouve bien que si une petite quantité de liquide a pu sourdre au moment des cathétérismes, le suc gastrique est resté inclus dans la poche stomacale et n'a pas pu en conséquence excorier ni digérer la peau périphérique.

Dans l'état actuel de la science la gastrostomie, telle qu'elle a été modifiée et réglée par Terrier et ses élèves, est l'opération de choix,

côté de la cavité stomacale. La Figure 1 représente le schéma de cette valvule. (Voir *Fig. 1*.)

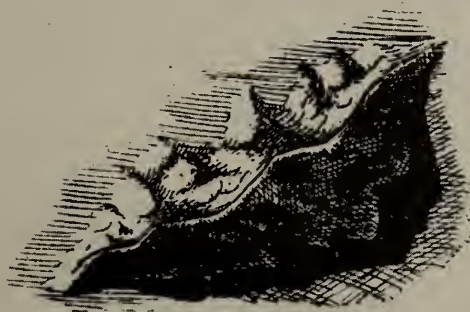


Fig. 1. — Valvule de la muqueuse stomacale vue en place.

Fig. 1. *Proof* from the literature that Pénieres made continent valves from mucous membrane in 1893, antedating Spivack by thirty-six years!

It is germane in this connection to recall what Petit de la Villeon⁹ said at the meeting of the Society of Surgeons of Paris in 1931:

"Use Fontan's method which he discovered and you will assure a continent gastric opening.

"Gentlemen, this opportunity offered me to speak to-

October 21, 1896

Une nouvelle opération de gastrostomie (procédé valvulaire).

Par le Dr FONTAN, de Toulon.
Professeur à l'école de médecine navale.

dodans constitue un pli valvulaire. C'est cette valvule formée préalablement, et aux dépens seulement de la muqueuse que M. Pelière avait obtenue dans ses recherches de laboratoire.

J'ai repris cette idée d'une opération valvulaire, en la modifiant d'une façon absolue au point de vue organique et chirurgical. Dans mon opération en effet toutes les couches de l'estomac font valvule, et non pas la muqueuse seulement; en second lieu je construis la valvule de toute pièce, en une seule séance, à l'aide d'un manuel opératoire très simple dont voici les principaux points.

Je dois dire que l'idée d'exécuter une opération valvulaire avait déjà été émise par M. Pelière, de Toulouse, qui, se préoccupant d'opérations à accomplir sur les viscères abdominaux, préparait dans ce but et en plusieurs séances, sur des animaux, des *valvules de muqueuse*. Lorsqu'on a suturé en couronne, aux lèvres d'une plaie abdominale la partie d'un viscère qui apparaît dans cette plaie ouverte, on obtient en quelques jours une surface bourgeonnante dont le fond est formé par la surface viscérale. Mais le bourgeonnement opérant un rapprochement des bords de

Fig. 2. *Proof* offered in the literature that Fontan is responsible for the first continent valve made from the whole thickness of the stomach. Photograph from Fontan's original article, antedating Spivack by thirty-three years!

"I wish to express to you my gratitude for the honor and tribute paid at the National Academy of Surgery, so justly merited to Professor Fontan, the great surgeon and marvelous teacher at the Medical School of Toulon of which I had the great honor of having been a student. You all know Fontan's operation of gastrostomy by means of a valve. I have assisted him in this operation a number of times, and have followed the cases postoperatively. I can assure you that these gastrostomies are continent and that these patients do not walk around with catheters in their abdomens nor any other contrivance.

"They keep their catheters in their pockets and use them only when they feed themselves.

day fills me with emotion and pride to express credit to and recognition to the name of my late lamented master and I appreciate the gesture of this surgical society of Paris surgeons and the rest of the great French surgical societies who have gathered here to pay homage to the name of Fontan."

The warmth of these sentiments are as they should be, shared as they are by surgeons of just sentiments the world over.

That establishes definitely who created the valve.

Who made the tube?

C. Formation of a Tube From the Stomach Wall by Dépage^{2,3} in 1901 and 1903 and by Janeway⁷ in 1913

Dépage, a Belgian, and Janeway, an American, formed a tube from the anterior wall of the stom-

This definitely establishes priority for the combination principle in gastrostomy.

E. What Has Spivack Done in This Connection, if Anything?

In 1929, three decades after the pioneers had

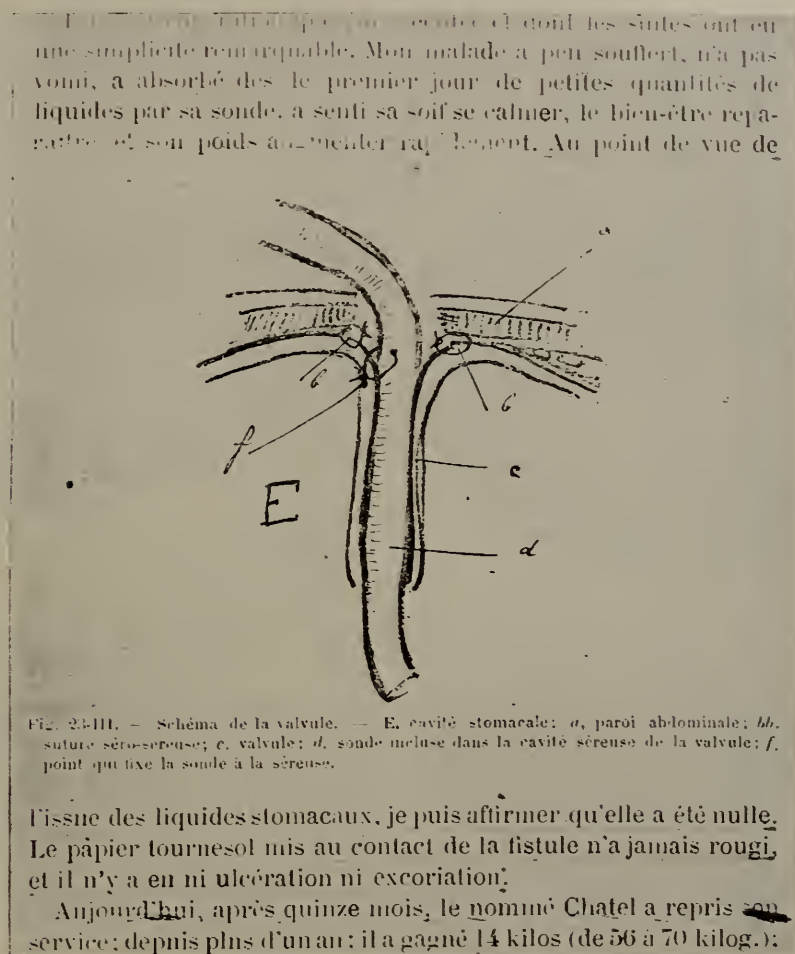


Fig. 3. Original illustration from the literature showing Fontan's valve.

ach lined with mucous membrane to provide a canal leading from the stomach to the skin surface. (Figs. 4 and 5.)

Here again we find that the publications of Dépage and Janeway precede Spivack by sixteen, twenty-six, and twenty-eight years, respectively!

This establishes decisively who perfected the tube.

Who was the first to combine two procedures?

D. The Combination Principle Was Originated by Watsudji¹⁹ in 1899

Watsudji combined the method of vonHacker with the Fontan technique in an operation stated to be unusually successful. (Fig. 6.)

completed their work, Spivack¹⁰ gave an account of "a new method of gastrostomy" (sic), stating that he had performed a "new operation" on nine dogs (not a single operation on a human being is reported in this communication.) He adds that this is his "personal method." (sic)

From the facts presented it at once becomes apparent that in this, his "new and personal method" (?), Spivack made use of the quarter-of-a-century-old technique of Dépage and Janeway's tube and Pénieres-Fontan's valve by a combination of the two. He called the procedure tubovalvular gastrostomy, and referred to it as "his personal operation." Obviously not very "new" nor very "personal."

Regrettably, dead men cannot object, but fortunately, the literature offers incontrovertible and eloquent proof to whom credit belongs for the principles of this operation. These are records that defy the teeth of time.

Lowry and Sorensen made a study of the literature, they would not have fallen into the same literary trap into which I stumbled before making a thorough survey on what had been written on the subject of gastrostomy. By caution in that

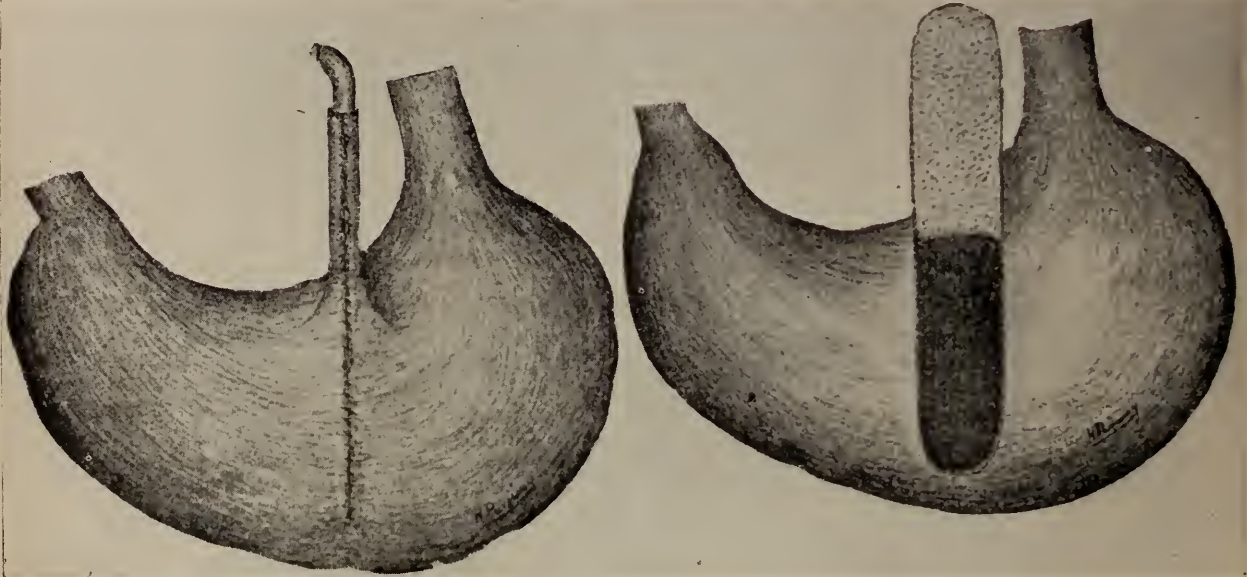


Fig. 4. Reproduction of *Dépage's* original article on the formation of a tube from the stomach wall which appeared in the *J. de chir. et Ann. Soc. belge de chir.*, "Nouveau procédé pour la gastrostomie." 1:715-718, 1901.

In discussing the exteriorization procedure of Mikulicz with Dr. Fred W. Rankin, he called my attention to the fact that the credit for priority in this operation belongs to Dr. Oscar Bloch. This stimulated me to study the literature on the subject. I made an exhaustive study and reported my findings in the *Annals of Surgery* (Vol. 106, July, 1937). These show that Mikulicz had done his operation in 1898. Oscar Bloch antedated him by seven years. Bloch reported his operation to his surgical society in Norway in 1891. Thus, credit for the exteriorization procedure unreservedly belongs to Bloch and not to Mikulicz.

Similarly, when one speaks of the Pólya operation, one is apt to forget that Reichel preceded Pólya by some years. Time often erases the credit slate, unless we constantly recall and keep historical truths before us.

It seems I was not the only one who originally wrote erroneously on this operation. About twelve years ago, Nelson H. Lowry and S. Sorensen^{7a} also committed the same error. This, obviously as I did, without consulting the literature and depending exclusively upon Spivack's nine-dog article.

I am persuaded to believe that had Doctors

respect we may well avoid the need of such remarks as: "The right Honorable Gautleman is indebted to his memory for his jests and to his imagination for his facts." (Sheridanian.)

It may be added that in a recent painstaking and exhaustive review of the literature on gastrostomy, Ferrari and Iturrapse⁴, of the University of Buenos Aires, again recognize the truth and state that tubovalvular gastrostomy described by Spivack is based on "the tubular gastrostomies of Dépage and Janeway, and the valvular gastrostomies of Fontan, Pénieres, and Senn."

Raymond W. McNealy and the writer made certain modifications in this operation^{11,14,15,16,17,18}; nevertheless, it would be hardly just for any of us to lay claims to a "new operation," because we made some modification on the original operative procedure. Because Watsudji combined two operative procedures of others, he certainly would not be justified in calling it "his" operation. He did not! He described his article, as "The combined use of the vonHacker and Fontan operations." Watsudji was obviously eager to give credit where credit belongs.

In the present war period and in the postwar period as well, there will be even more than usual

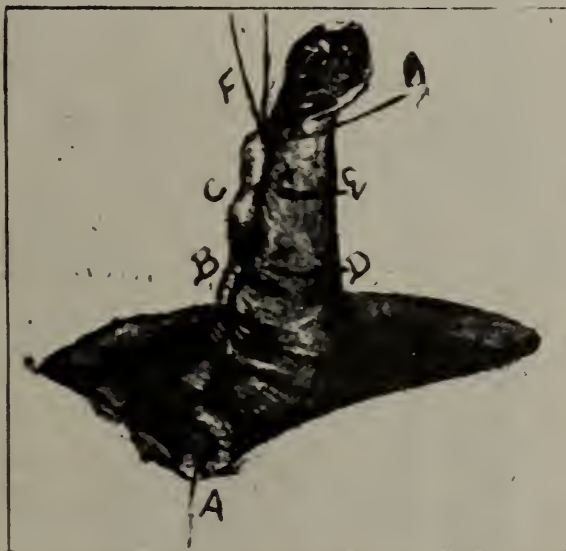
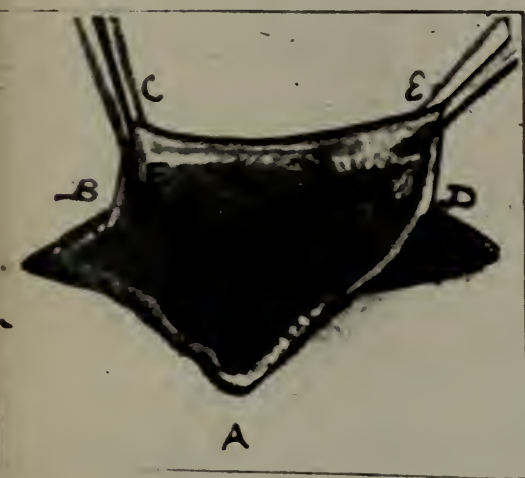
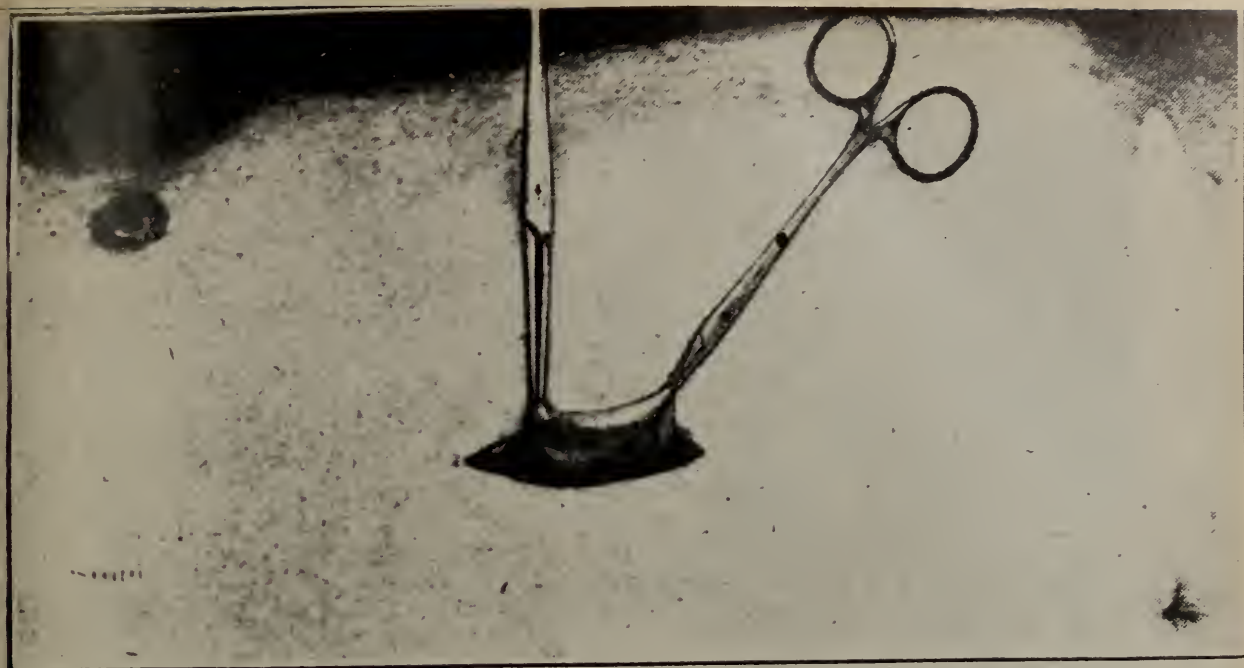


Fig. 5. Reproduction of Janeway's original illustrations of his article which appeared in *München. med. Wchnschr.*, "Eine neue gastrostomie-methode." 60:1705-1707, 1913.

migration of scientific men from one country to another for various personal and humanitarian reasons. The methods of the newcomer and some of the experiences and facts known to him may be new or foreign to his busy associates. It is, therefore, well, before giving full credit to anyone for alleged discoveries of new methods, to consult the literature painstakingly.

Apropos of this discussion and recognizing the need for an international, judicious and impartial decision respecting conflicting claims for priority in the surgical field, the International

Board of Trustees of the International College of Surgeons is now in the process of establishing an international body, made up of outstanding surgeons of each country of recognized character and ability, to act as a high court of honor among surgeons to see that due credit is given where credit is due.

Now as to the *technique* of the tubovalvular gastrostomy. This rests on basic principles evolved by the pioneers as outlined above. Fig. 7 (a, b, c, d, e and f), and the legends thereto, depict and describe the steps of the operation.

◎胃瘻術ニ於ケルハツケル、フォンテイン

ン二氏法ノ合成

醫學士 和辻 春次

人工胃瘻ヲ作爲スルニ當リ尤モ注意ヲ要シ而シテ殊ニ困難ナルハ其瘻孔半時ノ自然閉鎖ニ在リトス。輒今諸外科家カ種々ノ方法ヲ創意シ及ヒ之ヲ試ムルハ一ニ此困難ヲ排除セント欲スルニ外ナラズ就中ハツケル、ウィッツエル、フランク、コッヘル、カール、フォンテイン諸氏ノ法ハ世ニ應用セラレタルカ如シト雖モ症例ニヨリテ胃ノ狀況ハ多少ノ異同アルヲ以テ必ズシキ各法皆ナ適スル能ハサルハ固ヨリ論ナシ蓋シ久シク食道若クハ噴門狹窄アル者ニハ胃ハ頗ル萎縮ノ吾人カ希望スル率出ニ應セス直腹筋モ亦甚シク瘦削シテ其力ヲ逞フスル能ハザルヲアリ余ハ頃日臺北醫院ニ於テ一患者ノ食道下端ヨリ噴門ニ亘リテ發生セル癌腫ニ造瘻術ヲ施セリ而シテ此際ハツケル、フォンテイン二法ノ合成ヲ試ミ其頗ル好具ナルヲ覺ヘタルヲ以テ聊カ茲ニ同臭ノ一顧ヲ煩ハサント欲スルナリ

ハツケル氏法ハ皮截ヲ白線ニ平行シテ其左側直腹筋ノ中央部

ニ置キ前筋膜ヲ開キ次テ鈍性ニ斜メニ内方ニ剝離シテ直腹筋内縁ヲ強ク左側ニ牽引シ是ニ於テ前腹後葉ヲ皮截ト同位ニ開キ牽出シタル胃壁ノ圓錐ヲシテ直腹筋ノ緊張ニヨリ瘻孔閉鎖ヲ營マシムルニ在リ又フォンテイン氏法ハ八仙迷長ノ皮截ヲ肋緣弓下二仙迷ノ所ニ於テ之ニ平行セシメ直チニ截入シテ胃圓錐ヲ強ク牽出シ其基底ヲ腹壁、腹膜及ヒ筋腹後葉ニ縫着シテ以テ腹腔ヲ鎖サシ次ニ鑷子ヲ探リ圓錐ヲ胃内腔右側ニ摺入セシム則チ手袋指部ヲ翻轉スルカ如クシ溝腔ニ而セル漿液膜ヲ鑷子ノ周圍ニ於テ縫合シ僅ニ溝腔ヲ殘シ茲ヨリ小尖ヲ送リテ圓錐底ヲ穿チ「ドレイン」ヲ挿入シテ胃内ニ達セシム佛國ノロアソン氏ハ盛ニ此法ヲ用井同リカール氏ハ此際圓錐ヲ翻轉セザル前ニ於テ其尖端ヲ穿開シ置クヲ稱セリ又カール氏ハ胃前壁ヲ變換スルヲハウイツテル氏ニ倣ヒ「ゴム管」ヲ挿入スル所ニ胃壁ノ漏斗ヲ内腔ニ向フテ作爲セリ此點ニ就キハ少シクフォンテイン氏法ニ近似セルモノアリ

余ハ先ツ皮截ヲ左季肋部ニテ白線ニ並行シテ直腹筋中央ニ置キ凡ソ八仙迷長ヲ有セシメ筋腹ハ鈎ヲ掛クテ左方ニ退避セシ

(論說) 胃瘻術ニ於ケルハツケル、フォンテイン二氏法ノ合成

八百七十九

Fig. 6. Proof from the literature that Watsudji was first to combine two procedures in gastrostomy. He is thus entitled to the credit of initiating the combination principle. (From Watsudji, H.: The combined use of Fontan's and vonHacker's procedures in gastrostomy. Mitt. d. med. Gesells. zu Tokyo, 13:879, 1899.) It is evident that the combination of two operations in gastrostomy preceded Spivack by thirty years.

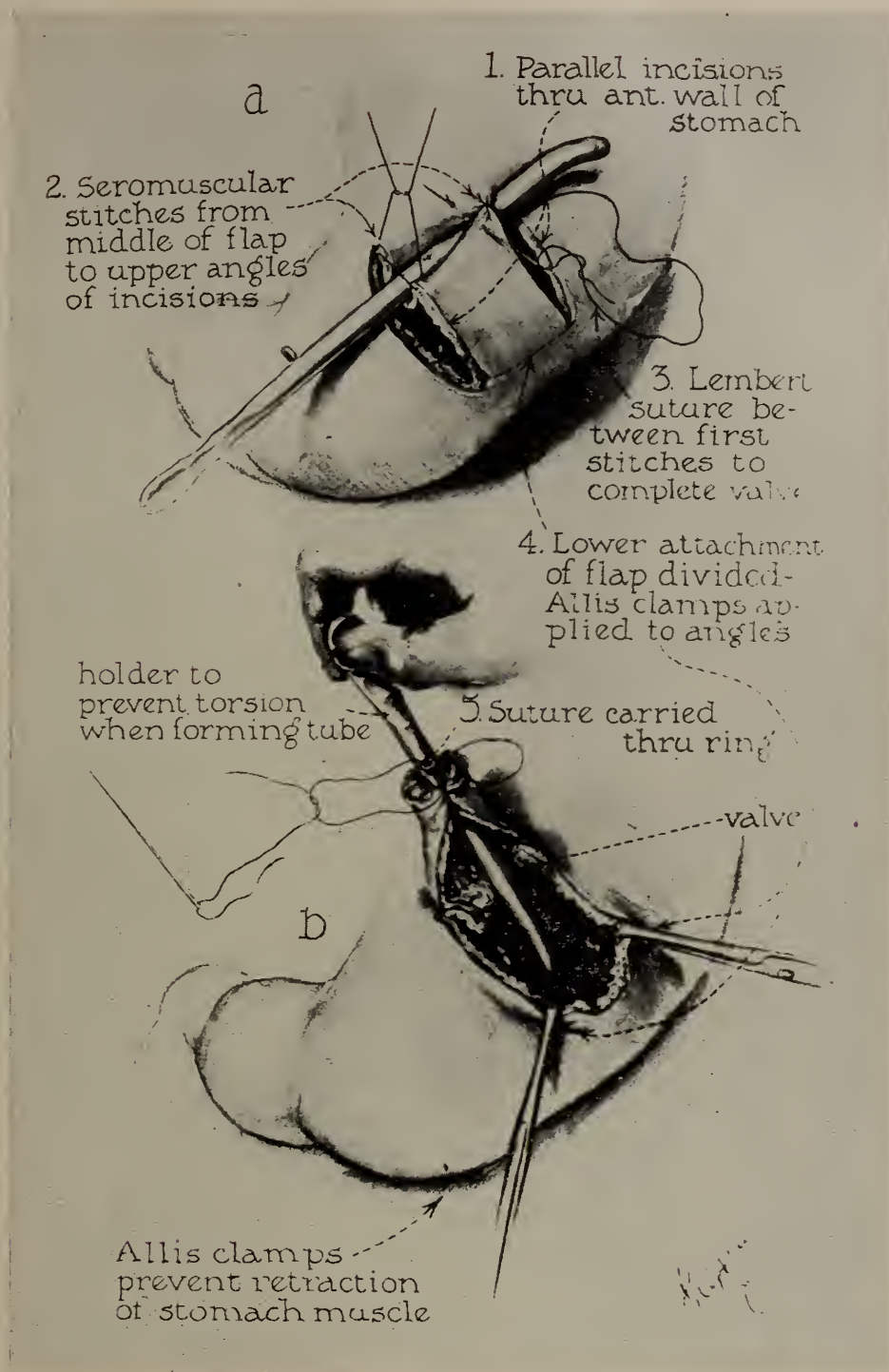


Fig. 7. Technique of tubovalvular gastrostomy. Formation of Dépage-Janeway tube. (a) The incisions are made as shown in 1. In 2 and 3, the method of making a Fontan valve from all the layers of the stomach is indicated. (b) In 4 and 5, the method of making a Dépage-Janeway tube is shown. A special sound devised by the author is a useful instrument to prevent torsion of the tube.

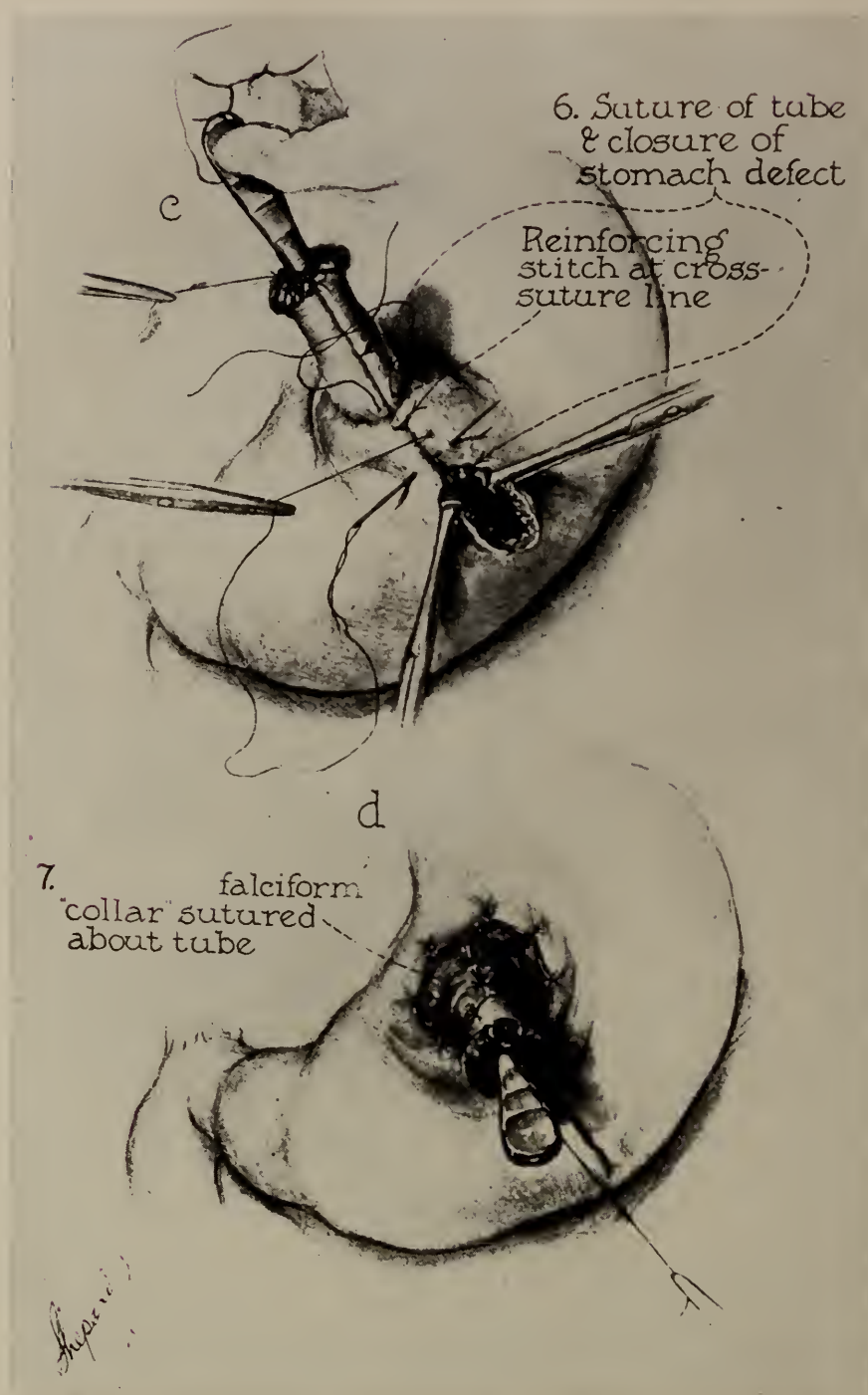


Fig. 7. (c) The Dépage-Janeway tube has been completed. Closure of the stomach is in progress. Note the reinforced step of cross-suture line, at the "vulnerable point" where the longitudinal suture line of the tube crosses original Lembert suture. (d) To reinforce the "vulnerable point" either McNealy's method of using the omentum or the author's modification of using the falciform ligament may be resorted to.

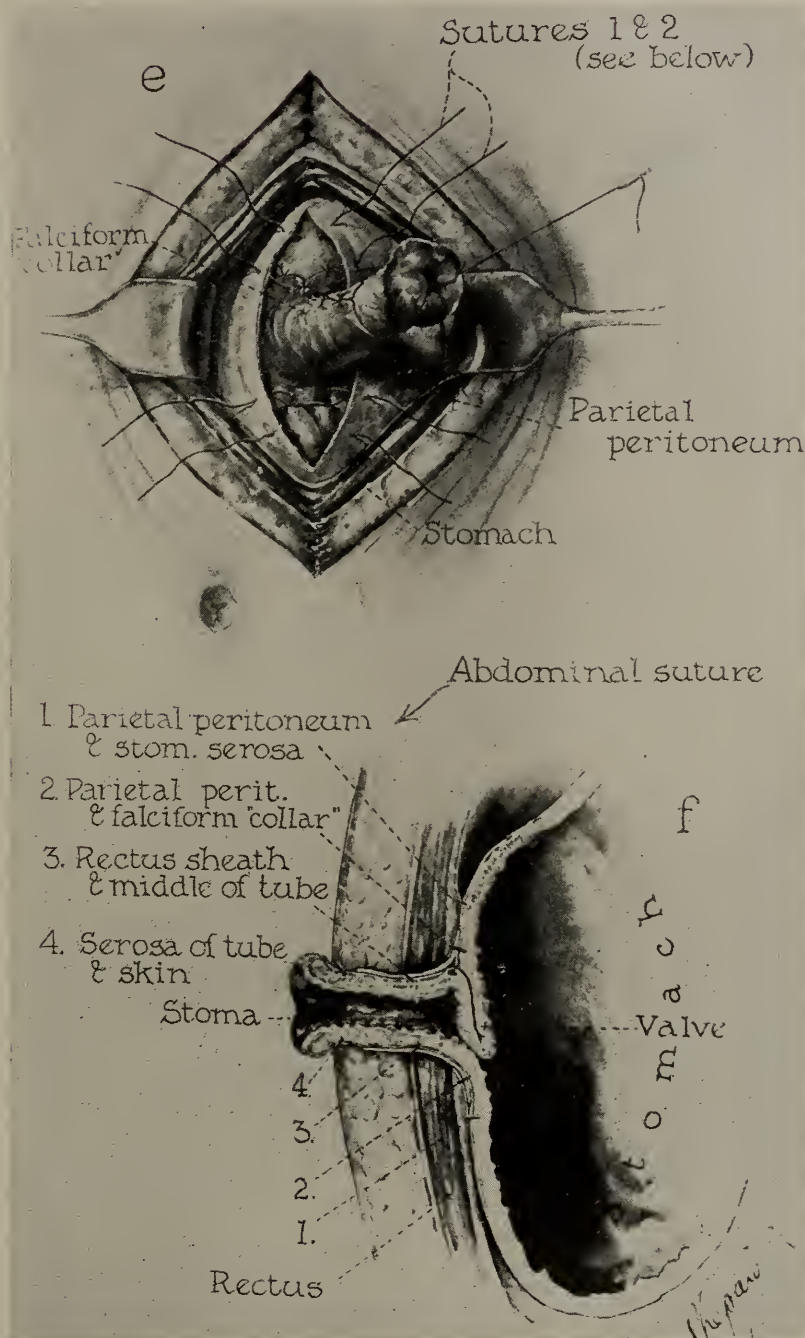


Fig. 7. (e and f) This shows the method of the implantation of the tube into the abdominal wall. Exact and firm anchorage of the tube is an essential part of the operation. In small contracted stomachs a long Dépage-Janeway tube may be formed by the author's method of opening the lesser peritoneal cavity and extending the original incisions along the posterior wall of the stomach and utilizing the flap thus obtained to make a longer tube. Note: For complete details of this operation consult the author's Modern Surgical Technic, Vol. 3, pp. 1287-1295 (J. B. Lippincott Co.).

Lesions where Gastrostomy Is Indicated

I. Diseases of the *pharynx*, the *larynx*, and those of cervical origin which affect those regions

1. Cancer of the pharynx and the larynx.
In cases of mechanical origin obstructing passage of food.

II. Diseases of the esophagus

1. *Cancer* of the esophagus
2. Incurable *cicatricial stenosis*
3. *Cardiospasm* or *mega-esophagus*
4. *Foreign bodies* in the esophagus
5. *Caustic esophagitis*
6. *Diverticula* of the esophagus
7. *Esophageal syphilis*
8. *Fistulas* of the esophageal region of traumatic, neoplastic or syphilitic origin
9. *Esophagopleural fistulas of neoplastic origin* or following empyemas or acute tracheobronchial adenitis
10. *Tuberculosis* of the esophagus

III. *Mediastinal lesions* which produce esophageal compression

IV. *Stomach lesions* (inoperable carcinoma of the cardia)

V. As a *therapeutic measure* (retrograde bougienage; retrograde radium)

Contraindications for Gastrostomy

I. Poor general *condition* of the patient.

II. Cases of tumor or *stenosis of the pylorus*.

III. Cases of *neoplastic invasion* of the *anterior stomach wall* or very extensive adhesions.

IV. Conditions not strictly contraindications but which make gastrostomy inadvisable are: cancers of the *lower part of the esophagus* or the *cardia*. Jejunostomy may be considered preferable here.

Should Tubovalvular Gastrostomy Be Used Routinely?

The answer is decidedly *no*.

For practical purposes, tubovalvular gastrostomy should be resorted to only by experienced surgeons who are thoroughly acquainted with the advantages, the technique and the dangers of operation. It is important to keep in mind that the operation is beset with many pitfalls and technical difficulties. Torsion of the newly formed tube is often followed by disastrous consequences. The operation is time consuming; this is an important factor in debilitated patients with low re-

sistance, et cetera. Nevertheless, after having resorted to the procedure for a number of years on numerous occasions I find it offers many distinct advantages. Before one decides to do this operation on patients, one should perform it, under guidance, a number of times on the dog.

Surgeons of limited experience will serve the interests of the patient best by resorting to the simpler methods of gastrostomy now practiced such as one of Fontan's, Dépage's, Janeway's, or Glassman's⁶ methods.

Summary

1. Historical facts of the evolution and the highlights of the technique of tubovalvular gastrostomy have been presented.

2. The need for an international body to study and evaluate claims for priorities on surgical operations is pointed out.

3. Proof from the literature is offered that:

(a) a leakproof valve, constructed from all the layers of the stomach was perfected by Pelière, Pénieres (mucosa) and Fontan (all layers of the stomach wall), some thirty years ago;

(b) a tube, constructed from all the layers of the stomach lined with mucosa was perfected by Dépage in 1901 and by Janeway in 1913;

(c) the principle of combining two procedures was first successfully used and recorded by Watsudji in 1899;

(d) in 1929, Spivack borrowed the ideas of the pioneer work of Dépage and Janeway as to tube formation, and those of Pelière-Pénieres, and Fontan as to valve formation, and Watsudji's combination principle and christened them tubovalvular gastrostomy, and called it wrongly his operation.

4. It is hardly just to the pioneers of surgery, dead or alive, to ignore their contributions to any surgical procedure. Credit should be given, therefore, unreservedly in tubovalvular gastrostomy to Dépage and Janeway of having created a tube, and to Fontan for having first created a continent valve from all the layers of the stomach; and to Watsudji for having resorted to a combination principle in gastrostomy. Certainly no credit is due any of us who made some modification on the original principles of the operation.

In the final analysis a Beethoven symphony will always remain a Beethoven symphony regardless of how many of us are trying to make "improvements" by tinkering with the original.

(Continued on Page 170)

Observations on Tropical Medicine in the United States Army

By Brigadier General C. C. Hillman, MC,
U. S. Army
San Francisco, California



Chief of Professional Service, Surgeon General's Office, War Department, Washington, D. C.; member of staff, County General and Letterman General Hospitals, San Francisco.

Since Pearl Harbor many thousands of our American physicians have become perforce doctors of tropical medicine. The problems that have been encountered in maintaining the health of troops in tropical climates among highly infected native populations have been legion. Each has necessitated detailed study and special measures to provide the solution. With typical American resourcefulness our medical officers have succeeded and, notwithstanding the unfavorable environment and hardships of campaign, death rates from disease among troops in tropical theaters have been far more favorable than among the civilian population of the United States.

The future suggests that for decades to come we shall have to maintain garrisons in equatorial areas. Tropical medicine becomes, therefore, a subject of practical interest and one that should command the earnest attention of our civilian practitioners and teaching institutions.

of the tropical world and necessarily have been exposed more or less closely to all of the important tropical infections.

Though in recent years a considerable volume of investigative work has been done by a few individuals in this country on some of these diseases, there remains the important fact that early in the war few of our newly commissioned medical officers had more than a rudimentary knowledge of tropical diseases or appreciated more than remotely their relationship to the success or failure of military operations. American physicians normally had had little or no contact with these maladies. Being a practical people, we lacked the stimulus for intensive study of diseases we rarely, or possibly never saw in our hospitals. This general lack of familiarity with tropical infections on the part of the civilian physician who had donned the uniform was reflected in the prevention and management of these diseases early in the war. Fortunately the shortcomings that appeared were short lived. The Medical Corps of the Regular Army had enjoyed a long experience with tropical infections in Panama, Puerto Rico and the Philippine Islands. Similar experience had been had by the Medical Corps of the Navy and the United States Public Health Service. In addition, a few individuals of the International Health Board, the Tennessee Valley Authority, and certain teaching institutions had been concerned especially with one or more diseases common to the tropics, or with the problem as a whole. With a free interchange of thought among these groups there were soon prepared in the Office of the Surgeon General of the Army brief but comprehensive directives covering the prevention and treatment of these infections among military personnel. Coincidentally there was established at the Army Medical School in Washington an intensive course in tropical medicine, and at the same time the obvious need stimulated an interest in the subject throughout the medical schools of the country. Through these means our medical officers in overseas theatres, and those going thereto, were soon provided with information with which to cope with the unfamiliar maladies met in tropical regions.

To effectively deal with tropical infections in military forces, it is necessary for the medical officer not only to acquaint himself with all phases of the problem but also to indoctrinate

■ Mr. President and members of the Michigan State Medical Society: Let me first express my appreciation of this opportunity to participate in the Michigan State Medical Society's Postgraduate Conference on War Medicine. I am happy to be with you and to recount briefly the experience of the Medical Department of the Army with tropical infections as they have occurred among military personnel during the current struggle.

Through your contact with the lay press you are well acquainted with the wide dispersion of our troops over the tropical regions of the earth. Beginning with Panama, the West Indies, and the Brazilian Coast in our own Western Hemisphere, you have been able to follow them through Central Africa, the Mediterranean Basin, Egypt, the Persian Gulf Area, India, Burma, Southern China, New Guinea, the Solomons and other islands of the Pacific. You will observe that our forces have operated throughout most

Read before the Fourth Annual Postgraduate Conference on War Medicine, the Seventy-Ninth Annual Session of the Michigan State Medical Society, Grand Rapids, Michigan, September 27, 1944.

officers and soldiers of the line with the nature and importance of preventive measures. As with other infectious diseases, an ounce of prevention is worth several pounds of cure, and prevention can be successfully accomplished only with the wholehearted co-operation of all members of the military force concerned. Leadership and supervision in matters of disease prevention constitute a most important phase of the medical officer's responsibilities in relationship to the success of military operations. That our medical officers applied themselves diligently to mastering the essentials of tropical diseases and at the same time provided effective leadership in matters of health in their units is shown by the threefold reduction in the incidence of these infections during the last year as compared with the earlier period of the war. These fine results attest eloquently to the versatility of the American physician in meeting his professional responsibilities, whatever they may be.

Malaria

The most important tropical infection with which we have had to deal is malaria. Our forces have operated in the most malarious regions of the earth. In many of these areas we found on our arrival primeval conditions and native populations almost universally infected with the malarial parasite. Under combat conditions in such regions it is not surprising that malaria was the greatest single cause of noneffectiveness. With the perfection of an adequate sanitary organization, the development of new larvacides, insecticides and repellents, the extensive use of suppressive treatment and full appreciation on the part of medical personnel and the line alike of the absolute necessity of rigid malaria discipline, it has been possible during the last year to carry on field operations in these intensely malarious regions with comparatively little depletion of our forces by the disease. That men coming down with attacks of malaria have received excellent care is shown by the fact that, in spite of a high proportion of falciparum infections, the fatality rate has been only one in 1000 cases (including many instances complicated by other diseases or injuries). The actual illness rarely lasts more than three days (two paroxysms at the most) and the average time in Army hospitals overseas is now about seven days.

Our greatest difficulty has arisen not from

the seriousness of the acute attack but, instead, from the high noneffective rate due to frequent relapses in vivax infections. In any given group of acute vivax cases one may expect from 40 to 70 per cent of recurrent attacks. The average period of remission increases while the severity of the attack and the likelihood of further attacks diminishes with each recurrence. Ten, fifteen, and even twenty or more recurrences have been reported, but these instances have been exceedingly rare (less than one-tenth of one per cent of those who have experienced initial attacks). The development of malaria cachexia has been very infrequent. Only about seven men in 1000 with malaria have been evacuated to the United States and many of these have been returned primarily for other reasons. With improved methods of management, the number is becoming less and less.

Even in remote areas patients have been well studied and an abundance of good statistical information exists. Through the movement of large bodies of troops from combat service in highly malarious regions to rest areas entirely free of the disease, unusual opportunities have been afforded for observing the delayed appearance of clinical manifestations, the characteristics and frequency of recurrence, and the effect of various drugs and combinations of drugs on the several phases of the disease. Furthermore, our experience has been concerned with large groups of nonimmunes rather than with populations which have at least partial immunity and whose reactions may be influenced to an undetermined extent thereby. From these studies overseas and others that have been carefully planned and carried out here in the States, we feel that we possess far greater knowledge of malaria than ever before.

Time will permit only a more or less categorical recital of our concepts of the drug management of the disease as it relates to suppression and to the therapy of acute attacks. They may be summarized briefly as follows:

(a) Neither atabrine, quinine nor any other known drug in reasonable doses prevents infection with the malarial parasite. Atabrine in 100 mgm. doses daily, except in rare instances, will prevent the appearance of clinical malaria and, continued after the standard treatment of the acute attack, will prevent recurrences. Reports

to the contrary are due, it is believed, largely to failure on the part of the patient to take the drug as prescribed.

(b) Atabrine or quinine properly administered will alleviate acute attacks and will eliminate trophozoites from the blood stream.

(c) Atabrine does cure falciparum malaria but vivax infections are not certainly eradicated by any known drug.

(d) The incidence of vivax recurrences does not appear to be influenced by the temporary administration of any known drug, except, that after standard treatment with atabrine, the average remission is definitely longer than after treatment with quinine. This may be explained by the slower elimination of atabrine from the body.

(e) No reliable method has yet been found to predict relapses or to demonstrate cure of malaria.

(f) The toxic effects of atabrine when properly administered are neither troublesome nor serious. Those of quinine, though usually not serious, are more unpleasant and frequent in their occurrence. Atabrine has been administered to large groups, 100 mgms. daily for many months at a time, with no clearly demonstrated ill effects.

(g) Quinine possesses no advantage over atabrine other than its more rapid action when administered intravenously in critical emergencies.

Plasmochin was employed in routine treatment early in the war in the hope that it would lessen the number of relapses. Carefully controlled clinical trials in Army hospitals at home and a large volume of reports from overseas lend no support to this thought. Moreover, its administration has been accompanied by serious and frequent toxic effects. While on an inspection of medical installations in the South and Southwest Pacific Theatres while its use was still in vogue, I was importuned frequently for authority to discontinue its use as a routine therapeutic measure because of the frequent toxic manifestations accompanying its use. It has since been discarded as having no place in the management of malaria in the Army.

Totaquine has been employed to a limited extent. Since its effect is essentially that of quinine, with even more frequent unpleasant side reactions, its extensive use is not anticipated.

There remains the great need for a drug that

will prove lethal to the malaria sporozoite as injected into the blood stream by the infected anopheles mosquito and to the resting vivax organism lying dormant in the human tissues between recurrences. Why the drugs at hand fail in this accomplishment is not understood. Until such a drug is available we cannot claim to have the ideal drug for prevention or cure. Though we know that the human being develops a varying degree of immunity following repeated attacks of malaria, the protective value is so uncertain and, in many cases, so slow in its development, that it is far from a satisfactory phenomenon on which to depend for recovery.

Dengue

Dengue is another mosquito-borne infection that has proved troublesome. It is a brief, self-limited disease, which, though stormy, takes no toll of life and leaves no residue. Out of this war's experience will come greatly extended knowledge of the clinical picture which by no means conforms as closely to the type description as we are taught. From an operational view, dengue constitutes a hazard only in that a large proportion of a force of nonimmunes may be infected and temporarily incapacitated simultaneously. In no instance has dengue played a significant role in military operations in this war.

Filaria

A third mosquito-borne disease which has been encountered in some islands of the Pacific is filariasis. Fortunately, the number of troops that have been stationed in the more heavily infested of these islands has not been great. Approximately 1000 cases have been reported in the Army. Doubtless there are more cases which have remained latent, but the total for the Army cannot be great. Suspected cases have been and are being studied with great care. Absolute proof of the diagnosis has been obtained in a small number of cases by the finding of adult worms in excised lymph nodes. It is reported that microfilariae have been found in the blood of three or four patients, but these reports lack confirmation. Certainly, repeated meticulous search so far has failed to demonstrate microfilariae at any time in practically all the cases. It is significant, however, that a high percentage of the natives in the islands in question have abundant microfilariae constantly in their peripheral blood.

American soldiers perforce lived in close proximity to these natives and by choice spent much of their time in their company.

The clinical developments in American soldiers considered to have filariasis are of great interest. In brief, the picture consists of repeated episodes of transient character, with malaise, slight fever, lymphatic swelling, redness, and tenderness. Both lymph nodes and lymph vessels are affected. Surrounding local tissues swell in such a manner as to make blockage as the cause seem well-nigh incredible. The genitalia, upper arms, and thigh are most commonly affected sites. Pain and tenderness suggest intra-abdominal involvement. Eosinophilia during an attack is the rule. The earliest recognized cases occurred about four months after first exposure. It is uncommon for these events to be incapacitating in themselves, although strenuous activity in some cases brings on an attack. Many men with the diagnosis have never been off duty until put in a hospital for study. Elephantiasis has not developed so far in a single case.

The Army early adopted the strict policy of returning men with the diagnosis of filariasis to the United States and protecting them from further overseas duty. Filariasis is not in itself a cause for discharge. Upon return to this country the attacks become milder and less frequent. We believe and hope that elephantiasis is unlikely to develop since the period over which infection took place was limited. Although natives are infected from childhood onward, elephantiasis rarely appears before the twenties and then is relatively uncommon even in a heavily infested population. In regard to the possible spread of filariasis in this country, the danger cannot be rated high, unless these patients develop microfilaria. Even in that case, control measures may be expected to be adequate. We should note that it is many years since a new case has been found in the focus which used to exist near Charleston.

Because of the mildness of the manifestations, the exceedingly small number in which microfilariae have been reported, and the definite tendency to spontaneous recovery, little experience has been gained with drug therapy among Army patients. No remedy is known to cure the disease but certain drugs, notably antimony preparations, are reported to be effective in re-

ducing the number of microfilariae in the blood stream. Of these, lithium antimony thiomalate appears to be the drug of choice.

Dysentery

Next in importance to malaria as a cause of noneffectiveness among troops in tropical areas is dysentery. Though occasional outbreaks are traced to carriers among mess personnel or to lapses in water discipline, the time-honored relationship between food, feces, and flies almost always is found to exist. With adequate excreta disposal, or the absence of flies, the problem of dysentery becomes negligible.

The bacillary form of dysentery is far more common than the amoebic. Though the shiga, as well as the less virulent types, have been encountered, the clinical manifestations usually have been mild and response to therapy has been prompt. The soldier practically always gets appropriate treatment early in the course of the disease. Chronic bacillary dysentery has rarely developed. Sulfaguanadine, the drug of choice a year or two ago, is giving way to sulfadiazine. Concentration of the drug in the lumen of the bowel appears not to be enough. To be most effective the drug must be absorbed, hence, the original supposed advantage of guanadine is not borne out. Shiga type antiserum has been available but has not proved to be a popular type of therapy.

The incidence of amoebic dysentery has been low. Few cases of amoebic hepatitis or liver abscess have been seen. Treatment with emetine, carbarsone and yatren is satisfactory in early and acute cases. The occasional chronic case continues to be a therapeutic problem.

Hookworm

The only other enteric affection that has been reported in considerable numbers of soldiers is hookworm infestation. In certain overseas theatres a fairly large proportion of certain units have become infected. Very few symptoms and very little anemia are reported. We are grateful for having available in hexylresorcinol and tetrachlorethylene relatively nontoxic and reasonably efficient agents to use against these worms.

"Scrub" Typhus

The most severe insect-borne disease that the Army has encountered in the tropics is "scrub"

typhus. It is an acute Rickettsial infection transmitted by a mite. Much valuable information about the epidemiology and clinical aspects of the disease was gained by an investigation team headed by Dr. Francis G. Blake, assisted by Dr. Kenneth F. Maxcy, sent to make an on-the-spot study in New Guinea late in 1943. They found that the larval form of the mite which is responsible for transmitting the disease is most prevalent in the coarse kunai grass adjacent to damp tropical forests, and that with clearing of the grass and drying of the ground the danger of acquiring the infection rapidly diminished. The importance of this disease lies not in the number of cases but in the high fatality rate, the mortality having varied in different series between 5 and 15 per cent. The clinical picture closely resembles that of louse-borne typhus with acute onset, moderately high elevation of temperature for two weeks or longer, dull red maculo-papular rash, severe headache, delirium and great prostration. Besides the generalized eruption there usually is a characteristic small round or oval punched out ulcer at the point of inoculation by the offending insect, a feature not found in louse-borne typhus. A positive agglutination with *Proteus* OXK usually is present. A negative test, however, does not exclude "scrub" typhus if all other characteristic features are present. The causative Rickettsia is readily recovered with suitable laboratory technique. There is no specific treatment. Good nursing care is most important and a long period of convalescence is indicated.

An effective vaccine against "scrub" typhus has not yet been developed.

Louse-borne typhus has been encountered in the Mediterranean Area and has required energetic control measures among the native inhabitants. This has consisted largely of delousing with the new highly-effective delousing agent known as DDT. American troops have been vaccinated against this type of the disease and have not suffered from it.

Sand-fly fever is a transient, nonfatal, self-limited, febrile virus infection transmitted by the *Phlebotomus papatasi*. It has been encountered in North Africa and the Near and Middle East. Until our medical men became acquainted with the disease it was frequently reported and treated as malaria. It is of importance in military medicine because of the number that may become

involved simultaneously upon the arrival of a nonimmune force in an endemic area. It has this characteristic in common with dengue. In addition sand-fly bites are very troublesome in certain individuals.

Cutaneous leishmaniasis (oriental sore) has been encountered in small numbers in the Near and Middle East and two or three cases have been found among evacuees returned to this country. The infection responds well, but somewhat slowly, to antimonials such as neostam and neostibosan.

The generalized form of leishmaniasis, known as kala azar, is endemic in India but no official reports of its occurrence among American troops have been received.

Many infections with *Schistosomum mansoni* are found in Puerto Rican troops but these units are kept in that area. No cases have been reported from elsewhere.

A half dozen infections with *Schistosomum hematobium* have been reported from North Africa and one case was seen among evacuees from that area in a general hospital in this country. Treated reasonably early these infections respond well to Fuadin, an organic antimonial.

A few cases of relapsing fever have been encountered in India. They respond readily to mapharsen or neoarsphenamine.

Skin Infections

Skin infections have made a sizeable contribution to the morbidity rates among our troops in tropical regions. The epidermophytoses and coccus infections account for the most of these. They are favored by the high temperature and humidity, excessive perspiration, and frequent traumata of the skin from scanty clothing habits in the tropics. Many of these cases are very resistant to treatment and improve only with evacuation to the States.

The so-called tropical ulcer has been encountered occasionally. There is no specific etiology. It has resulted usually from miscellaneous infections in neglected traumatic ulcers. The lesions respond well to bed rest and simple local treatment. The wearing of long trousers is helpful in prevention.

So far American soldiers have not suffered from trypanosomiasis, bubonic plague, Asiatic cholera or yellow fever though they have operated in regions where these diseases are endemic.

Protective vaccination is employed against the latter two of these diseases.

Though I have mentioned a number of tropical infections from which our military forces in overseas theatres have suffered, the over-all mortality rates have been surprisingly low. Among troops overseas last year only one man in 2000 died of disease. There were five times as many deaths due to nonbattle injuries. It will perhaps astonish you to know that arteriosclerosis, including coronary occlusion, was the leading cause of death from disease in overseas theatres.

Only one-third of the deaths from disease were due to communicable causes and only one-sixth to the so-called tropical diseases. These and other less mathematical reports indicate that the sick soldier, even when he has a "tropical" infection, receives medical care of a high order.

Spread of Tropical Infections

During the last year or two much has been written about the possible introduction and spread of tropical infections among the people of the United States by soldiers returning from tropical theatres. Some have expressed quite pessimistic outlooks. These, I believe, have based their fears largely on theoretical grounds, oversimplifying highly complicated ecologic systems and neglecting important economic and social factors in epidemiology. Neither have they taken into account our intimate knowledge of these infections nor the high efficiency of our public health system in dealing with matters of this kind. While we will undoubtedly have an occasional new focus of malaria and see veterans afflicted with maladies of tropical origin, I cannot share the fear that the health of the American people will be significantly affected by them.

In expressing the above opinion, however, I do not mean to infer that we should not maintain, and even increase, our interest in tropical diseases. In terms of distance the earth has become small as compared with the past. Trade and travel with other parts of the world, including the tropical world, will be greater than before, and to fulfill our responsibilities toward maintenance of the peace it is inconceivable that sizable Army and Navy garrisons will not be maintained in tropical regions. To meet these obligations and to be prepared for the next emergen-

cy, which we fervently hope will never come, we must advance our knowledge of tropical diseases as well as those pathological conditions that are more frequently met at home. With the start that has been made in our teaching institutions and laboratories and the intense interest that has been awakened among our medical men serving overseas, it would appear that the stage is set for brilliant accomplishments in this field following the war. Let us not fail in providing support to bring this hope to full fruition.



Tubovalvular Gastrostomy

(Continued from Page 164)

5. Tubovalvular gastrostomy is a difficult operation and should not be resorted to by the inexperienced whose patients will fare better by using the standard simpler procedures (Fontan, Dépage, Janeway or Glassman).

6. It is well to remember that before any operation or procedure is presented as new, a thorough search of the literature will often disclose that many so-called "new" and "personal" operations are not "new" at all, *but quite aged and very "impersonal."*

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Three Out of Four Haven't Heard of It!

"QUESTION: *Have you ever heard of a medical service plan sponsored by the medical profession?*"

This question was asked our Michigan people in the recent Survey of Public Opinion sponsored by the Michigan Health Council.

Less than one-fourth (23.8 per cent) of the people of Michigan had ever heard of a medical service plan sponsored by the Michigan State Medical Society. Most of the voters (75.4 per cent) did not know that a highly successful alternative to compulsory governmental medicine exists in Michigan. *This is a calamity!*

Moreover, many subscribers enrolled in *Michigan Medical Service* (the plan sponsored by the Michigan State Medical Society) actually do not know that this nonprofit program for their protection was organized in 1940 by the medical doctors of Michigan themselves!

Compare this lack of vocal public relations on the part of our medical men to the well-organized and highly articulate campaign used by proponents of governmental political medicine!

Doctor, Michigan Medical Service is something to be proud of—something to shout about! Start your constructive work in behalf of MMS at once. There is much work to be done with little time to do it, so we in the medical profession must work fast and hard. We must continue our support of Michigan Medical Service, extend the service as rapidly as possible to the maximum number of people, and make the program as comprehensive as is practical.

Michigan Medical Service, with its 750,000 subscribers in Michigan, is OUR program—not one controlled and operated by government. Tell the people about it.

AS Brunk

President, Michigan State Medical Society



President's



Page



Editorial

FUTURE CAREERS IN MEDICINE AT STAKE!

■ *The proposed amendment to the Constitution of the State of Michigan would control and dictate your entire future career in the practice of MEDICINE. We cannot make this statement too emphatic. This amendment has been prepared and—if approved through a concurrent resolution by the Legislature—will be submitted to the people of the state.* If voted upon favorably at the spring or any other election, it will destroy the private practice of medicine and dentistry in this state.*

This amendment would provide on the state level ALL HEALTH SERVICES on a tax-supported basis. Under this state-controlled and operated program these health services would include:

1. Complete medical, surgical, obstetrical, including preventive and therapeutic, and special appliances and eye glasses.
2. Complete Dental, including oral surgery and prophylaxis.
3. Pharmaceutical.
4. Hospital (in nonprofit institutions, including convalescence).
5. Nursing.

A Social Insurance Fund, which is actually a STATE INCOME TAX and a Payroll Tax, is provided to defray the expenses of this vast "Social Security" program. It would be raised as follows:

1. The employer will pay one and a half per cent on all payroll, in addition to all other deductions and contributions to unemployment compensation.
2. The taxpayer will contribute one per cent of all income up to \$1,000 annually, two per cent of all net income between \$1,000 and \$2,000 annually, and three per cent of all net income in excess of \$3,000.

A Director of Health Insurance would be authorized to make arrangements with duly licensed practitioners (which term includes doctors

of medicine, osteopaths, chiropractors), specialists, consultants, and clinics for services and supplies.

It's YOUR entire future career at stake!

WHY? Because an immense hoax is about to be perpetrated on the public and on the Medical Profession of Michigan.

HOW! Through an amendment to the State Constitution, proposed for a public vote next spring (if approved by the 1945 Legislature).

WHAT kind of an amendment? An amendment to set up a fantastic compulsory "cradle to the grave" Social Insurance system for Michigan, derived by a *second income tax* for the State of Michigan.

This is a panacea proposal with exceedingly dangerous popular appeal. It is a hoax because it promises vastly more than it can possibly deliver. It would inevitably make all our doctors "State Doctors."

MEDICAL TREATMENT FOR VETERANS NOW

■ "A large and growing number of veterans of this war who need and are unable to get medical services and hospital treatment" has been noted in the public press (*Detroit News*, Dec. 17, 1944). Veterans' organizations representing Wayne County, Detroit, and the State of Michigan have laid the situation before Brig. Gen. Frank T. Hines, Director of the Veterans' Administration at Washington, urging that he act promptly in providing hospitalization for veterans. New Hospitals are under plan and construction, but will not be available for months, and the need is *now*.

The Michigan State Medical Society hopes that authorization will be made at once for the use of private hospitals, and care by private physicians. Under the law these men are entitled to hospitalization and medical and surgical care at the expense of the government, but the bureau interprets that as meaning when there are facilities and bureau doctors available.

That does not care for the veteran in need now. He has given of his best for the benefit of

*This amendment has been analyzed and discussed in the JOURNAL, page 592, August, 1944; page 907, October; page 944, November; page 1092, December; and page 68, January, 1945.

the people and the government, and it is his due that care be provided him without stint and when he needs it. We well remember how it was after the last war. Veterans were sent in "for examination and report." Many of them came back every six months for "examination and report," but the recommended treatment *was* given—hospital beds were made available. The use of private hospitals and private physicians was suggested. We hope the suggestion will TAKE, and something will be done NOW. There are private hospitals and private physicians in sufficient numbers to care for all the needy veterans, and they are ready and anxious to serve. All that is needed is the authorization from the Bureau in charge of the Veterans' Administration.

IS THE RACE IMPROVING?

■ The first million draftees of the last World War, (1917-18) measured an average of 67.49 inches in height. This was in the age group from 21 to 30. The average height of the 20 to 29 age groups of inductees of this war up to May, 1943, was 68.15 inches, about two-thirds of an inch higher. In the same groups the proportion of men 70 inches tall was 27.5 per cent as against 22.4 per cent in the last war. The proportion of men six feet tall is now 8.8 per cent as against 6.5 per cent in the last war. The general average height as well as the number of tall men is greater.

A study of school children in Toronto in 1939 showed the average six-year-old was actually two inches taller than the same aged child in 1892. At nine years this difference was three inches, and at fourteen years the boys were three and a half inches taller and the girls two inches.

The stature of the average young person must be accepted as an indication of better physical condition. The rejection rates of this war have been used to challenge the medical profession for a job poorly done. The standards have been higher, and added causes for rejection have been used. In this war seven per cent were rejected because of illiteracy. This one item alone would account for the higher rejection rate.

It is of first consideration from a health standpoint, as well as military, that the physical condition of our young people be placed on a high level. This is of direct interest to the medical profession, and we accept the challenge, but we cannot be held responsible for some of the factors causing the high rejection rates. The medical

profession cannot be blamed because 7 per cent of our young men and women cannot read or write.

During the twenty-five-year period between the two wars morbidity and mortality rates have decreased and the life expectancy has increased from 49 to 61 years. We feel pride in the manifest improvement of the race as shown statistically. But the medical profession is pledged eternally to improve it.

ASSESSMENTS

■ The House of Delegates of the Michigan State

Medical Society at its September, 1944, session voted a \$5.00 assessment for a postwar medical veterans' readjustment program which will employ a postwar counselor (a doctor of medicine) who will study and evaluate the problems of our returned military members with regard to (a) relocations; (b) postgraduate education; and (c) finances. There are so many problems arising under this category and so many benefits and plans in operation that it will tax the ingenuity of a wise man to sort out the special advantages as they may apply to a certain individual. The House of Delegates proposes that our returning soldier members shall have the benefit of every opportunity and advantage open to him.

The House of Delegates also voted to continue the special \$10.00 per capita assessment for public education purposes which proved its value during the past twelve months. This assessment, as in the past, will be earmarked for the exclusive purpose of public educational programs. The work accomplished during the past year has been productive of much good, and will be directed to the same end in 1945.

Both these assessments were effective January 1, 1945, and are to be paid before April 1, 1945. They will be in addition to the regular twelve-dollar annual dues to the Society. This makes \$27.00 to be paid to the County Society Secretary in addition to the County Society dues.

Our members have notably paid their dues in good season, but this year, with so many important problems and programs it is essential that all the doctors still in practice at home pay their dues early. Fully a third of our members are in the military service, and are not paying dues, thus the stay-at-homes have a greater responsibility and a greater privilege. We must maintain the home front.

Let's all write a check at once and mail it to the County Society Secretary.

A REPORT ON THE RUSSIANS

Extracts from the *Reader's Digest* condensation of a forthcoming book by William L. White*

Medical Care in Russia

"Although visiting Soviet doctors are given free access to Allied hospitals on the Western fronts, it is most difficult for Allied medical observers to visit Soviet field hospitals. This is not entirely because of the traditional Russian suspicion of foreigners. They are a proud people, and they conceal their weaknesses.

"Their general standard of medical care cannot compare with that of the Western countries. They spend freely on the more spectacular branches of medical research, but under this top crust the average Russian doctor has less training than a good American nurse. So when permission to visit a Russian hospital is refused—by the Soviet method of delay and postponement—the real reason often is that the Russians know that the foreigner would learn nothing new except the meagerness of their equipment. For *the general poverty of the country extends to medicine.*

*Reprinted by special permission of the *Reader's Digest*.

"This poverty of resources and training at the bottom is obscured by a thick cloud of ballyhoo for their achievements at the top. It was recently proclaimed that their medical scientist Burdenko had developed a technique for removing and preserving live nerves so that they could later replace nerves destroyed in paralyzed limbs. Instantly the outside medical world was interested. But the method was a Russian military secret. The kindest explanation may be that it was only in the laboratory stage, from which it may never emerge. After all, premature medical ballyhoo is certainly not a Marxist monopoly."

* * *

"We wonder how much politics has to do with the scarcity of skilled brains here. Suppose the Democratic Party were limited to about 4,500,000 members, and that no man could hold a responsible job whose loyalty to the Secretary of its National Committee was in any way questioned. Many good men might have to be discarded because they were not politically sound."

ADVANCED COURSE IN SURGICAL ANATOMY AT THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

March 1-June 14, 1945 (Thursdays)

A course in Anatomy under the direction of Professor Rollo E. McCotter is offered to physicians wishing a review in this field. Such a course has been requested especially by surgeons and those preparing for specialty board examinations.

The course will be given on Thursdays, beginning March 1, at 1:00 P. M., and ending June 14. The

first part of the afternoon will be devoted to an informal lecture followed by practical studies in the Anatomical Laboratory. The evening hours to 10:00 o'clock will be devoted entirely to laboratory work.

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PROCEEDINGS OF THE MSMS HOUSE OF DELEGATES — 1944

(Published in December, 1944, and January and February, 1945, issues*)

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MICHIGAN STATE MEDICAL SOCIETY

Seventy-ninth Annual Session

Proceedings of the House of Delegates

Grand Rapids — 1944

(Continued from January issue)

XIII-6 (a). MEDICAL VETERANS READJUSTMENT PROGRAM AND SPECIAL ASSESSMENT

DR. BRASIE: Resolution No. 1, submitted by Dr. Catherwood.

"WHEREAS, More than 2,100 Michigan doctors of medicine in the armed services, where they have performed so brilliantly, will be returning soon, and the medical profession and this House of Delegates are faced with the immediate responsibility, as well as the privilege, of preparing to assist them in a realistic manner, and

"WHEREAS, A study of the situation shows that the returning doctor will be faced by any one or a combination of these three problems: Where to locate, further professional education, finances; and

"WHEREAS, There are many projects under way by various hospital staffs, local county medical societies, state societies, American Medical Association, American College of Surgeons, American College of Physicians, and others, indicating the necessity for co-ordination, therefore be it

"RESOLVED, That necessary funds be allocated by the Council of the Michigan State Medical Society to procure the full-time services of a counselor on postwar adjustments, said counselor to be a part of the regular executive administration of the state society, and be it further

"RESOLVED, That the Michigan State Medical Society request each county society to appoint a postwar adjustment committee to co-operate with the counselor."

Dr. Catherwood and Dr. Babcock appeared before the Committee and spoke rather eloquently for this resolution, explaining why they thought it was a good thing and why they wished to carry it.

The Committee approved of the Resolution with the following addition:

"BE IT RESOLVED, That the Counselor selected to handle the problems of returning veterans should be a doctor of medicine whose services could be used for other activities."

The reason for that was, it was felt that a counselor if employed, in the process of preparing all the work to be necessary, there might be times when his services could be used for other things and they did not wish to excuse him in that respect.

There was one other thing added:

"BE IT FURTHER RESOLVED, That a special assessment of five dollars for each member of the Michigan State Medical Society be levied during the coming year to be used exclusively to implement this resolution."

Now, although there is a following resolution for special assessments coming up, the Committee felt some funds should be especially allocated to this endeavor. They also felt any member of a Michigan State Medical Society who would object to contributing five dollars a year for a few years to help rehabilitate the fellows who fought for them, probably wouldn't dare say so.

Therefore, with the inclusion of these two additions to the resolution, Mr. Chairman, I move the acceptance and adoption of this portion of the report.

DR. BABCOCK (Wayne): I second the motion.

THE SPEAKER: Is there any discussion?

S. L. LOUPEE, M.D. (Cass): Speaking of the financial needs of such a program as this, it strikes me, within the state of Michigan, through the legislative act of 1943, I believe a large sum was set aside to provide for the care of returning veterans. Certainly

medical men are worthy of special consideration from the hands of those who administer this fund. I speak without authority. This is only an idea which has come to my mind to the effect that it might be possible that properly supported and properly managed, an appeal to the administration board for help along this line to returning medical veterans might be easily obtained and justifiably obtained. I think, here is a chance to get some funds; only, we as a group must go at it wholeheartedly and not leave it up to some one or two or three to put the thing over. If you can sell it to your own people that help is needed for rehabilitation along those lines to a special group who are rendering a wonderful service to society in general, it may be easy to get a special contribution for this purpose. I have no authority. I am just offering this suggestion.

I also want to debate the idea of taking on another five dollars which means fifteen dollars of special assessments and although I have no objections to paying the special assessments, I am of the opinion that the time will come when the fellows back home will say enough is enough. It was ten dollars last year, and this year it will be fifteen dollars, and then perhaps twenty dollars next year. Where is it going to stop?

The cause is worthy, but there is plenty of money being appropriated by the State of Michigan to take care of all returning veterans, medical men included.

DR. MCCLELLAN (Wayne): I think I recognize the justice of Dr. Loupee's remarks, but every time you take government money, you take it with strings. That has been the history of our bureaucratic money. We have had a great deal of discussion on some of the other money that has been appropriated through government bureaus. I question whether a government agency will allocate funds to be disbursed by private agencies. I furthermore feel, this is an obligation of the medical profession to its own brothers and while it is true, as Dr. Loupee says, it is five dollars here and now another ten dollars, I would like to call attention to the fact that one of the things that has provoked the most discussion on this floor and will provoke more, is the status of the osteopath and they have established themselves by being willing to spend a few dollars for their own protection.

I would like to see this contribution come from the members of the medical profession.

DR. LOUPEE: As to the issue of medical funds, I am wholly in accord with what Dr. McClellan has said. There is no question but what strings are always tied to the allocation of government funds. In this instance, however, this appropriation has been made. It does not come from the federal government. It comes from our own state. It is made by our own legislature. It is definitely delegated for us for the returning veterans. We have no right to expect any special allocations, but if we could get it, there would be nothing wrong about it and no strings tied to it. None whatsoever. I merely offer this: It is possible if we get together and make the appeal and support it within reason and justice, we will get somewhere. If we don't we will pay it ourselves.

THE SPEAKER: Is there further discussion? The motion then, is to approve the report, plus the amplification by the Reference Committee. All in favor of the motion say "aye"; opposed? Carried.

XIII-6(e). ASSESSMENT FOR PUBLIC EDUCATION

DR. BRASIE: There is another resolution pertaining to special assessments. The original resolution reads as follows: Resolution No. 24:

"WHEREAS, It appears that the public has not been sufficiently informed as to the true motives behind certain movements to change the system of medical care, nor of the deterioration in medical service that will result if such movements materialize, and

"WHEREAS, Considerable administrative work will be necessary during the coming year in order to assist in a practical way the returning medical war veteran; therefore be it

"RESOLVED, That the membership of the Michigan State Medical Society be assessed \$10.00 per capita for educational purposes and postwar professional readjustment costs during 1945."

Inasmuch as the previous resolution just moved and passed contained, with the additions made by the Committee, a special assessment for the purposes of professional postwar readjustments, this resolution was changed to read as follows:

Now, the original assessment as it appears in the resolution, was left standing at ten dollars by the Committee with the firm belief that it would be discussed from the floor and you could take what action you pleased. Therefore, the resolution now reads as follows, and we offer it as a substitute:

"WHEREAS, It appears that the public has not been sufficiently informed as to the true motives behind certain movements to change the system of medical care, nor of the deterioration in medical service that will result if such movements materialize, and be it

"RESOLVED, That the membership of the Michigan State Medical Society be assessed \$10.00 per capita for educational purposes."

Mr. Chairman, I move the adoption of this resolution as amended by the Resolutions Committee.

DR. LOUPEE: I second it.

THE SPEAKER: Is there a discussion? Is there any discussion? All in favor of the resolution as amended by the Resolutions Committee say "aye"; opposed? Carried.

DR. BRASIE: We have a resolution submitted by Dr. Insley which states: Resolution No. 22.

XIII-6 (f). RECOMMENDING VARIOUS STUDIES TO MMS

"WHEREAS, The Michigan State Medical Society has always been in the vanguard of leadership in matters pertaining to public health responsibilities, and

WHEREAS, The Michigan State Medical Society was the original sponsor of Michigan Medical Service some years back, and

"WHEREAS, Michigan Medical Service has by this date demonstrated its physical and financial soundness in its present scope of activities, therefore be it

"RESOLVED, That the Michigan State Medical Society now requests the Michigan Medical Service to make appropriate studies with the ultimate aim of further improving its usefulness by integrating the numerous health services now being offered by various public and semi-public agencies."

Dr. Insley appeared before the Committee with a very interesting chart and a very interesting explanation. I think we will let Dr. Insley present that himself.

It was agreed by the Committee to add also to this resolution, the following:

"BE IT FURTHER RESOLVED, That the acts ascertained by such a study should be presented to the Michigan State Medical Society House of Delegates, and be it further

"RESOLVED, To participate in any such proposed programs must pass a common Board of Examiners named by the State Medical Society."

The reason those were added is because this resolution carries a great amount of implication as I think you will see when Dr. Insley explains it, and it was

felt by the Committee that certainly if it were worthy of study, the results of that study should come before the House to be discussed before any direct action is taken. The remark was made by one or two that even if a special session were necessary, these things should not be undertaken short of the House of Delegates. I don't say this in disparaging the resolution.

I move the adoption and acceptance of this portion of the report.

THE SPEAKER: If you don't mind, it is now seven minutes to one and I am very sure we can't cover this. I wonder, would you be satisfied to hear Dr. Insley's explanation and then renew your motion? Is that agreeable to the House? Is Dr. Insley here?

DR. BRASIE: Dr. Insley was unable to be here and he left his chart and asked that it be presented and shown to the House.

DR. MCCLELLAN: Will he be here tonight?

THE SPEAKER: How long would it take to show this chart? About ten minutes?

DR. MCCLELLAN: It took him longer than that to explain it to the Committee last night.

THE SPEAKER: If that is the case, we will defer further action until our session tonight. We will entertain a motion to adjourn. We will convene at eight this evening.

(Upon motion duly made and seconded, it was voted to adjourn. The meeting recessed at twelve fifty-five o'clock.)

Tuesday Evening Session

September 26, 1944

The meeting convened at eight-fifteen o'clock, with The Speaker presiding.

THE SPEAKER: Is the Credentials Chairman ready to report?

J. J. O'MEARA, M.D.: Mr. Chairman, I hold here in my hand, the credentials of over 60 per cent of the accredited House of Delegates, 50 per cent of whom are not from any one county.

THE SPEAKER: If there are no objections, the Credentials Committee's report will be accepted as the roll call of this evening.

Before we start on our regular duties, I am going to ask one of our old-time delegates who is here, who was elected a delegate this year to just take a bow. Harvey Hansen, representative of Calhoun County for many years, now Major Hansen.

(Major Hansen arose and was applauded.)

THE SPEAKER: We will return then to unfinished business. When we ended this noon, we were on reports of the Reference Committee on Resolutions. Dr. Brasie.

DR. BRASIE: Mr. Speaker, Delegates of the House: At the time of the adjournment, we were considering the Insley resolution which I will read as amended by the Committee.

"WHEREAS, The Michigan State Medical Society has always been in the vanguard of leadership in matters pertaining to public health responsibilities, and

"WHEREAS, The Michigan State Medical Society was the original sponsor of Michigan Medical Service some years back, and

"WHEREAS, Michigan Medical Service has by this date demonstrated its physical and financial soundness in its present scope of activities, therefore be it

"RESOLVED, That the Michigan State Medical Society now request the Michigan Medical Service to make appropriate studies with the ultimate aim of further improving its usefulness by integrating the numerous health services now being offered by various public and semi-public agencies, and be it further

"RESOLVED, That the facts ascertained by such a study should be presented to the Michigan State Medical Society House of Delegates, and be it further

"RESOLVED, To participate in any such proposed programs must be voluntary on the part of the members of the Michigan State Medical Society."

This is the resolution as amended by your Resolutions Committee. Mr. Chairman, I move the acceptance and the adoption of this report.

DR. GRUBER: (Wayne): I second it.

THE SPEAKER: Now, as a part of our discussion, we are going to have an exhibit prepared by Dr. Insley and presented by Dr. McClellan. Well, I don't see him here. That being the case, we shall have to dispense with the exhibit. Is there further discussion?

All in favor of the motion to accept this resolution as amended please say "aye"; opposed? The motion is carried.

XIII-6 (g). STUDY OF MEDICAL PRACTICE PROCEDURES

DR. BRASIE: We come now to a series of resolutions pertaining to the osteopathic situation. The first one is from Wayne County. Resolution No. 14.

"WHEREAS, It appears that many osteopaths are prescribing drugs and practicing therapeutics in violation of Act 162 of the Public Acts of 1903, and

"WHEREAS, Such violations of the laws of the State of Michigan are detrimental to the public health and welfare; therefore be it

"RESOLVED, That when the present emergency ceases, steps be taken to clarify the status of osteopaths, particularly in regard to the practice of therapeutics, and be it further

"RESOLVED, That as the preliminary step, the judicial decision of the Supreme Court of Nebraska defining the limits of osteopathy, and the action of the state medical societies of California and New Jersey toward absorbing the osteopaths be studied."

The Committee unanimously recommends that this resolution be adopted as read.

Mr. Chairman, I move the acceptance and adoption of this report.

(The motion was seconded.)

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed? Motion is carried.

XIII-6 (h). QUALIFICATIONS OF PRACTITIONERS OF DRUG THERAPY

DR. BRASIE: The second resolution was introduced by Dr. Pino. Resolution No. 19.

"WHEREAS, All comprehensive practice of the healing art by individuals who profess to use medicine and surgery includes the use of chemicals, drugs and biologicals which if not skillfully administered may become dangerous to individuals and the public health, be it

"RESOLVED, That any practitioner or group of practitioners of the healing art who use such chemicals, drugs or biologicals must pass a common Board of Examiners named by the state and acceptable to the Department of Medical Therapeutics of the universities of Michigan, and be it further

"RESOLVED, That the Michigan State Medical Society through its Council and Legislative Committee, give consideration to the promotion of such legislation."

The Committee felt that the first resolution read covered this resolution and that while this resolution was slightly more specific, still it is covered in the resolution just passed. For that reason, and for that reason only, I move that this resolution be accepted and placed on the table. Rather, I move this resolution be accepted and filed.

W. B. MCWILLIAMS, M.D. (Clinton): I second it.

THE SPEAKER: Is there any discussion on this motion that this resolution be accepted and filed? If not, all in favor of the motion say "aye"; opposed? The motion is carried.

XIII-6 (i). CONSULTATION SERVICE OF UNIVERSITY OF MICHIGAN HOSPITAL

DR. BRASIE: The next resolution also pertains to this subject. Resolution No. 32.

"WHEREAS, There has been reported the adoption of a policy by the administration of the University Hospital to the effect that the staff of the hospital submit reports of findings of pa-

tients and further advice relative to treatment of such patients to osteopaths, and

"WHEREAS, The University Hospital constitutes an integral part of the University of Michigan Medical College, a pre-eminent institution in medical education, and

"WHEREAS, If true that such consultation reports or advice is furnished to osteopaths; it would appear to constitute recognition of osteopathy by this leading institution of medical training and science and to possibly thus undermine the dignity and prestige of its own graduates of medicine, therefore be it

"RESOLVED, That The Council be instructed to ascertain from the administration of the University Hospital the facts concerning this question and if as reported, to urge the cessation of such practices."

The Committee believes that the sense of the motion as a protest be approved, but that action be deferred until the status of the practice of osteopathy in the state of Michigan has been determined.

The reason for that was, that again the first resolution by eventually determining the status of osteopaths, would seem to have to guide the further action.

Mr. Chairman, I move the acceptance and the adoption of this report.

THE SPEAKER: I am not quite clear on that. There are apparently two parts; one which you approve and the other you do not approve. Is that right?

Will you reread just the resolved part of that over?

DR. BRASIE: It has been requested the resolution be reread.

"RESOLVED, That the Council be instructed to ascertain from the administration of the University Hospital the facts concerning this question and if as reported, to urge the cessation of such practices."

The Committee recommends that the sense of the motion be approved, but that action be deferred until the status of the practice of osteopathy in the State of Michigan has been determined.

Mr. Chairman, I move the acceptance and the adoption of this report.

THE SPEAKER: Is there a second?

L. W. HULL, M.D. (Wayne): I will second it.

DR. GRUBER (Wayne): I move, as an amendment to the motion, that the original resolution be adopted. My reason is, in all probability, the University of Michigan is laboring under the same difficulties that all Institutions are laboring under at the present time. The prosecuting attorney for the county of Wayne is determined that it is necessary for the institution at Eloise to co-operate with the osteopaths. In all probability the University of Michigan has had a like ruling from the Attorney General's office. So far, I have not complied with the interpretation of the prosecuting attorney of the County of Wayne.

I believe the original resolution as put in is proper and should be looked into. I believe the Council should look into the matter and if the Attorney General has made such a ruling, they should try to dissuade him of such a ruling. I believe the original resolution as presented is correct, and I move the original resolution should be approved.

A. E. STICKLEY, M.D. (Ottawa): I second it.

THE SPEAKER: Do you all have it clearly? We are voting then, on Dr. Gruber's motion which is to adopt the resolution as originally presented to the Reference Committee. Is there any discussion? All in favor of the motion say "aye"; opposed? The motion is carried.

XIII-6 (j). RE: EMIC

DR. BRASIE: The following resolution is on the EMIC program. Resolution No. 28.

"WHEREAS, The EMIC program was referred to the Council for study, and

"WHEREAS, A special committee of the Council was assigned to the task, and

"WHEREAS, After many meetings and conferences were held with representatives of the Childrens' Bureau, health authorities, specialist groups, general practitioners, hospitals and other interested groups, and

"WHEREAS, As a result these alternatives were presented by the Council to the profession, namely:

- (1) Sign the blanks to provide for hospital service, giving professional care gratis; or
 - (2) Sign the blanks and accept the government fee for medical care; or
 - (3) Decline to participate in the program, as physicians see fit, be it
- "RESOLVED, That this action of the Council be approved."

This resolution was approved by the Committee after considerable debate, unanimously. Mr. Speaker, I move the acceptance and the adoption of this report.

DR. SIMPSON (Wayne): I second the motion.

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed?

Dr. Harm, did you want to discuss that?

W. B. HARM, M.D. (Wayne): I would like to ask, at the present time, does the EMIC program contain a fee of \$75 for the specialist and \$50 for the general practitioner?

THE SPEAKER: No sir.

DR. HARM: I was given to understand it was, by Dr. DeKleine.

THE SPEAKER: If you wish, Dr. DeKleine will answer that for you. Dr. DeKleine, will you answer the question?

DR. DEKLEINE: You asked whether or not the fee of \$75 was approved?

DR. HARM: To a specialist.

DR. DEKLEINE: An increase of 50 per cent of the regular fee may be allowed to both obstetricians and pediatricians. Therefore, \$75 may be allowed for specialists in obstetrics, and an increase of 50 per cent to pediatricians.

THE SPEAKER: For clarification, I wish to ask you a question. I understand that has been allowed by the Childrens' Bureau, but has the Michigan Department of Health taken advantage of that permission or are you still allowing the same fees?

DR. HARM: Has the State Council sanctioned it?

DR. DEKLEINE: The matter is in the Department of Public Health.

THE SPEAKER: So far, you have not taken advantage of that rule? Therefore, up-to-date, specialists and pediatricians are receiving the same fee?

DR. DEKLEINE: Yes.

THE SPEAKER: Does that answer your question?

DR. HARM: I would like to amend the resolution, gentlemen, that we adopt with probation; the fees to be the same to all specialists.

THE SPEAKER: Dr. Harm, if you don't mind, I would like to ask you not to make such a motion, for this reason: We cannot control that. Now, may I be at liberty to tell about our special meeting, Dr. DeKleine?

DR. DEKLEINE: Yes.

THE SPEAKER: Dr. DeKleine has appointed an Advisory Health Committee to help him in this particular question. On that Committee, he has very generously appointed all three members of the State Societies' EMIC Committee. They are, Dr. Keyport, Dr. Foster and myself. At a meeting on September 14, this question was brought up and the Advisory Committee was not in favor of making that change. So far, the state department is abiding by the wish of the Advisory Committee. It seems to me that is all we should ask. However, if you want your motion restated, you can have it. I don't think we can carry it out in effect. If you wish to restate it, it is all right.

DR. HARM: May I make a few remarks? Last year, on the Maternity Bill, we voted for the Maternity Bill. When it came up, we found it included everything of a medical nature that could happen to a pregnant woman—ingrown toenail, headache or broken arm—all of which we did not know last year at the meeting. We adopted the Maternity Bill at that time and those things were added afterwards.

It seems now as it goes along, things are going to be added every day or two. In fact, this proposition is the same.

THE SPEAKER: Will you restate your motion then,

Dr. Harm? If you still want to make the motion, will you please restate it?

DR. HARM: That the resolution read: That the fee paid be the same to all physicians and to all practitioners of medicine.

THE SPEAKER: Is there a second to that motion? There is no second. Is there further discussion? Are you ready for the motion to adopt the report of the Committee?

DR. GRUBER (Wayne): What is this about the specialist getting \$75? Is that what they are after?

THE SPEAKER: May I explain it once more to you?

DR. GRUBER: No, I don't want an explanation. I just want to ask something. Who is going to determine who is a specialist in obstetrics? Dr. DeKleine or who?

THE SPEAKER: That was also gone over at the meeting at the same time and I will tell you the way it was mentioned: Those who are members of the Specialty Boards in the various specialties will be considered as specialists.

DR. GRUBER: May I make a comment? I think that is a cockeyed idea. (*Laughter and applause*)

W. A. SIBRANS, M.D. (Macomb): I think that is a very cockeyed idea. A man can deliver a baby; he may not be a specialist, but he can deliver it under peculiar circumstances and still not be a specialist and he receives \$50, while another man who is specializing in the subject receives \$75.

THE SPEAKER: Is there further discussion on the resolution?

DR. HARM: I would like to ask if there were any general practitioners at this committee meeting?

THE SPEAKER: Yes, there were. We have the list somewhere. I don't think I have it here, but I know that there were. Dr. DeKleine, would you tell us how many general practitioners are on the Advisory Committee?

DR. DEKLEINE: Two general practitioners, Dr. Wilbur Tousley and another doctor from Lansing, two obstetricians, two pediatricians and—

THE SPEAKER: And myself.

DR. INSLEY (Wayne): Is the discussion still pertinent to Dr. Harm's motion?

THE SPEAKER: No, that had no second. The discussion is on the original motion made by Dr. Brasie to adopt the resolution.

DR. INSLEY: Would it be possible to make a second to the motion so the sentiment might be expressed here tonight?

THE SPEAKER: The Chair will entertain a motion, if you wish to make one.

DR. INSLEY: I would like to make a motion to the same general effect as Dr. Harm proposed a few moments ago so as to bring the matter up.

THE SPEAKER: Please state your motion, Dr. Insley.

DR. INSLEY: That the fees to be paid on the EMIC program shall be of a uniform character on a sliding scale for specialists and general practitioners.

THE SPEAKER: Inasmuch as we have made some progress in the discussion, the Chair will entertain the motion.

DR. HARM: I second the motion.

THE SPEAKER: Dr. Insley moves that the fees be uniform for this program for specialists and general practitioners.

DR. GRUBER: I don't think that is a fair motion. I think there should be a level stated in the motion. You know very well and everybody else knows very well that it is going to be on the lowest level. I think there should be a level stated in Dr. Insley's motion.

THE SPEAKER: Dr. Gruber, may I say this once more? I want it to be perfectly clear. I think we can express sentiment on this only. We have no power to enforce those things.

Is there further discussion on this motion?

DR. LOUPEE (Cass): I have been trying to deter-

mine where we are. As I understand this resolution as presented and proposed to be passed, it virtually does away with this program except at the volition of the individual practitioner. Is that not right?

THE SPEAKER: Correct. Under that, may I say something?

DR. LOUPEE: No, I want to carry out this thought I have in mind. You are doing away with this program except as the individual practitioner decides to cooperate or not. Then, you turn right around and as a group you decide that we shall have a certain fee. Now, I would like to know where there is any fairness in that thought? You agree to do away with a program in one resolution and in the next resolution, you want to stipulate a fee. They are not in common accord as I can see it. If we are going to leave the thing out on the limb, and I am heartily in sympathy with Dr. Brasie's motion, that we can function or not as we see fit, as individuals. Therefore, I cannot see why we as a society should under the same motion determine that the fee shall be this or that. I would have nothing to do with it. I would accept what they have in mind to pay us or keep out of the picture. It isn't a question of money. We know it isn't a question of money, that we function under the ruling. We all know that. It is a question of medical ethics and our own idea of the trend of state medicine today. Therefore, if the motions are not harmonious, they should not come together, according to the way I see it.

THE SPEAKER: Maybe we don't all understand that. We have been working under the very system that this resolution proposes, since last March. This was passed originally by the Council. It was passed originally by the Executive Committee of the Council and put into effect as of March of this year. Now co-operating under the plan are 1988 doctors of medicine. Therefore, it doesn't throw the plan out. The Council is the backer of this resolution and it was put in simply to have the sanction of the House of Delegates on this action that was taken by the Council on this very controversial thing.

DR. LOUPEE: That is exactly the idea of it. Therefore, why intermingle these resolutions or these motions? Why not act upon the original motion as presented and approve or disapprove of the action of the Council and take up the other matters as outside affairs. I don't see why you don't do that.

THE SPEAKER: The Chair has accepted the original and the amendment.

C. E. TOSHACH, M.D. (Saginaw): I think this motion is an unfortunate motion in that we are in a situation where we ought to present a unified front to the powers that be in Washington. This motion unquestionably is going to divide ourselves one against the other. From the beginning of time it has been known that specialists get a larger fee than general practitioners. No motion of this society is going to change that situation. Therefore, the motion has no value. Secondly, if this motion passes, it means every specialist will be lined up against every general practitioner. That would be a very unfortunate situation at the present time. I very earnestly hope we will turn down this motion.

THE SPEAKER: Is there further discussion on the amendment?

DR. HARM: In talking to Dr. DeKleine, he said the increase of 50 per cent in fees holds in surgical on the EMIC program and also the pediatric division. That is just for your information.

THE SPEAKER: Is there further discussion?

GEORGE WOOD, M.D. (Northern Michigan): I want to speak on one point only and that is the point of the fee. The question has been brought up, What is a specialist? and it has been made to appear that a specialist is worth more than a general practitioner and

the idea seems to be carried out in that \$75 is given to the specialist.

Now, the question I would like to ask is this: We recognize a man who does nothing but obstetrics. He works in a hospital, has all the conveniences to work with, and a horde of nurses to wait on him. He is a specialist and gets \$75. How about the doctor who has to drive twelve or fifteen miles out in the country in the middle of the night to deliver a pair of twins on a dusty couch and do delivery under those conditions without any infection? Isn't he as much of a specialist as the one who is recognized as a specialist?

I want to bring out that point that I think if this motion is adopted and can be carried through, that the \$75 fee is perfectly legitimate and earned by the general practitioner in the country as well as the specialist.

L. J. MORAND, M.D. (Wayne): Inasmuch as I do no obstetrics, I feel qualified to speak. Now aren't we wasting a lot of time? After all, we are not going to change it, and whether the services of a specialist are worth \$75 and those of a general practitioner worth \$50, we are not going to set the rule. It is not going to make any change at all, and we are wasting a lot of time. If any general practitioner wishes to get \$75, all he has to do is pass his board. I call for the question and let's not waste any more time. We are not going to change it anyway. I call for the question.

W. A. SIBRANS, M.D. (Macomb): I think we might settle the whole question in this way as I have done in my practice. Where they have allowed \$40 on the EMIC and where you have allowed the different changes in price, I usually can't get the patient to add to that price.

THE SPEAKER: Are you ready for the question? All in favor of Dr. Insley's amendment which is that it be a standard fee for both under this program—for both the specialist and general practitioners, please say "aye"; opposed? The motion is lost.

Will the "ayes" please raise their hands? I don't think there were many but I want to be sure.

(Eight members raised their hands.)

THE SPEAKER: We will now vote on the original resolution. Are you ready for the question? All in favor of Dr. Brasie's resolution please say "aye"; opposed? The motion is carried.

DR. BRASIE: I do not wish to seem insistent, but once again my name has been attached to a resolution. This resolution was not presented by Dr. Brasie. It was prevented by another gentleman and the resolution before the floor comes from the Reference Committee on Resolutions. May I ask that it be corrected in the records?

THE SPEAKER: That is the resolution just passed. I said, "The motion of Dr. Brasie—"

DR. BRASIE: Will you add, as Chairman of the Reference Committee on Resolutions?

THE SPEAKER: That is not his motion.

DR. BRASIE: We are going much faster than I had anticipated. We have one more resolution—two more resolutions.

Resolution No. 19.

XIII-6 (k). COMMENDATION OF MMS ADMINISTRATION

"WHEREAS, Michigan Medical Service has provided the means whereby several hundred thousand people of this state have been able to secure medical care on a prepaid budgeted basis, and

"WHEREAS, This medical care has been rendered in a manner which has been generally highly satisfactory to both patient and physician, and

"WHEREAS, This has resulted in better feeling and understanding between the public and the medical profession, and

"WHEREAS, The present management of Michigan Medical Service has made a splendid record in financially rehabilitating the corporation and in harmonizing differences, be it

"RESOLVED, That we, the members of the House of Delegates of the Michigan State Medical Society in meeting assembled

this 25th day of September, 1944, wholeheartedly commend the President and the officers and directors of Michigan Medical Service for their splendid achievement, and be it further

"RESOLVED, That a copy of this resolution be sent to AMA and to each county society and a suitable copy to each officer and member of the Board of Directors of Michigan Medical Service."

There is one correction. The original motion said "Chairman" instead of "President."

The Committee on Resolutions approved this by a majority vote.

Mr. Speaker, as Chairman of the Resolutions Committee, I hereby ask the acceptance and adoption of this report as amended by the one substituted word "President" in place of "Chairman."

H. F. DIBBLE, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed? The motion is carried.

DR. BRASIE: Resolution No. 31.

XIII-6 (1). ENLARGING MMS BENEFITS

"WHEREAS, Requests have been made of Michigan Medical Service to study various phases of services now provided, and

"WHEREAS, The present bed shortage in the hospitals in the various communities of the State is of a so serious a nature as to endanger the public health, be it

"RESOLVED, That Michigan Medical Service is hereby requested to study ways and means of providing for the performance of minor surgery in the physician's office. This change in the present procedure to take precedence over any other extension of Michigan Medical Service."

The Committee on Resolutions approved by majority vote this resolution with the deletion of the last sentence, namely:

"This change in the present procedure to take precedence over any other extension of Michigan Medical Service."

Mr. Speaker, I move the acceptance and the adoption of this report as deleted by the Resolutions Committee.

DR. WALKER (Wayne): I second it.

THE SPEAKER: Is there any discussion on the motion?

DR. LOUPEE (Cass): I want to ask a question. Did the Committee make any calculations as to what extent this change is going to benefit the osteopaths as they proceed to do this kind of work within their office?

THE SPEAKER: Dr. Brasie will answer that.

DR. BRASIE: I can honestly say that particular phase of the question was not brought before the Committee. That is the only honest answer I can give you.

THE SPEAKER: If there is no further discussion, we can vote.

W. W. BABCOCK, M.D. (Wayne): I can't help but feel that the passage of such a resolution would cause a deterioration of the surgery done generally because those doctors who are not allowed to operate in hospitals under any conditions, would do so in their own offices. I also feel that the term "minor surgery" should be defined in that resolution to let us know exactly what it encompasses.

DR. REEDER (Genesee): This has been a controversial matter for some time. I think you all know me, gentlemen. It seems to me this part of minor surgery connected with this thing is nothing short of kindergarten. Just consider my city for instance, a patient is admitted to the hospital with a little wen on his head and another with a little lymphoma on his back and another one with an ingrown toenail, and the rest of us are begging to get major elective surgery and those beds are occupied. Gentlemen, I simply cannot see the justice of the thing. There must be some way to settle this thing. Any one of those conditions—and those are just a few of the minor things—could be done under a little local anesthesia in your office and you are depriving some really sick case, some major condition, of your institution.

I think it is just a matter of common sense. Can we not, or cannot the Michigan Medical Service or the

Michigan Hospital Association get together on such stuff? It is just common sense. There is nothing to it. Sit down and think it over. When you do have somebody injured in an accident case or acute appendicitis, or anything you might call an emergency, you can't get a bed because somebody's got it who has a wen on his head or a lymphoma on his back or an ingrown toenail. Does that make sense? That is all I am pleading for in behalf of this resolution. There must be some way the Michigan Hospital Association in connection with the Michigan Medical Service could make an adjustment someplace.

THE SPEAKER: The speaker would like to point out that this resolution calls for study only. Is there further discussion? If not, all in favor of the resolution say "aye"; opposed? The motion is carried.

DR. BRASIE: Mr. Speaker, I now move the acceptance and the adoption of the report of the Reference Committee on Resolutions as a whole.

B. G. HOLTOM, M.D. (Calhoun): I second it.

THE SPEAKER: Is there any discussion? All in favor say "aye"; opposed? The motion is carried.

Thank you, Dr. Brasie. I want to thank Dr. Brasie and his Committee especially at this time for having their report ready at ten o'clock this morning. It was a tremendous amount of work to get this ready. Thank you very much.

DR. BRASIE: Thank you, Mr. Speaker.

THE SPEAKER: We will go on then with unfinished business. Are there any supplementary reports of the Council? The Supplemental report on the Reference Committee on Officers' Reports?

L. W. DAY, M.D. (Hillsdale): Mr. Speaker, The Supplemental Report of the Committee on Officers' Reports.

XIII-1 (a). SPEAKER'S ADDRESS

Your Committee on Officers' Reports has reconsidered its original report of the Speaker's address as requested by the House of Delegates at its ten o'clock session of September 26, 1944.

This Committee now recommends the following change of phraseology of Recommendation No. 3, to read as follows:

"That in keeping with the 'Declaration of Medical Policies' adopted by the House of Delegates of the Michigan State Medical Society last year, we will resist participation in any future health program that is inaugurated without first being submitted to this Society for approval."

Mr. Speaker, I move the acceptance of the Speaker's report with the proposed change of phraseology.

D. W. THORUP, M.D. (Berrien): I second it.

THE SPEAKER: Is there any discussion? All in favor say "aye"; opposed? The motion is carried.

Are there any supplemental reports from the Reference Committees on Standing Committees?

D. C. BEAVER, M.D. (Wayne): There is no report.

THE SPEAKER: Thank you, Dr. Beaver. From the Reference Committee on Reports of Special Committees? Dr. Wenger.

A. V. WENGER, M.D. (Kent): No supplemental report.

THE SPEAKER: Is there a supplemental report by the Reference Committee on Constitution and By-Laws?

DR. HESS: No supplemental report.

THE SPEAKER: At this time we are about to take up the delicate matter of the Chippewa-Mackinac County Society. The Chair will entertain a motion for executive session.

DR. LUCE (Wayne): I move that this assembly form itself into an executive session for the discussion of the subject referred to under the Chippewa County Medical Society.

G. L. COAN (Wayne): I second it.

THE SPEAKER: Will you see that the House is cleared for members of the House of Delegates?

The House of Delegates went into Executive Session. After free discussion, the following motion was adopted: "The Fact-Finding Committee recommends the granting of the petition of The Council relating to the revocation of the Charter of the Chippewa-Mackinac County Medical Society, effective January 1, 1945, provided the functioning county medical society representative of all medical groups is not operating at that time."

XIV Elections

(Upon motion duly made and seconded, it was voted to rise from executive session.)

XIV-1. COUNCILOR 14th DISTRICT

THE SPEAKER: We are now ready for elections, and the first officer to be elected is the Councilor to the 14th District.

J. S. DETAR, M.D. (Washtenaw): Mr. Speaker, Dean W. Myers is a highly respected physician and man in the 14th District because he is a leader of medical men in that district and because his term has been a very short one and because it is the unanimous opinion of the physicians of the 14th District, the counties of Lenawee, Livingston, Monroe and Washtenaw, that his services have been excellent and we have been well represented, I wish to place before this body, the name of Dean W. Myers to succeed himself as Councilor of the 14th District.

E. T. MORDEN, M.D. (Lenawee): I second it.

THE SPEAKER: Are there any other nominations? If not, the Chair will entertain a motion for unanimous ballot.

DR. JOHNSON: I so move and that the Secretary cast the unanimous ballot.

DR. BUSSER (Wayne): I second it.

THE SPEAKER: All in favor say "aye"; opposed? The motion is carried.

THE SECRETARY: I cast the unanimous ballot for Dean W. Myers as Councilor of the 14th District.

XIV-2. DELEGATES TO AMA

THE SPEAKER: Next, is the election of delegates to the American Medical Association. Nominations for that office are now in order and there are three to be elected.

DR. BREAKEY (Ingham): I should like to renominate Henry A. Luce of Detroit to succeed himself.

(The motion was seconded.)

DR. CATHERWOOD (Wayne): I would like to place in nomination the name of Claude Keyport, M.D., to succeed himself.

DR. SPRINGER (St. Joseph): I would like to place the name of an efficient, aggressive, experienced crusader for all the ideals of organized medicine, Dr. GRUBER.

THE SPEAKER: Are there any other nominations?

DR. CHRISTIAN (Ingham): I move the nominations be closed and the Secretary be instructed to cast the unanimous ballot of this organization for the three men.

DR. SIMPSON (Wayne): I second it.

THE SPEAKER: You have heard the motion. Is there any discussion? All in favor, say "aye"; opposed? Carried.

THE SECRETARY: I cast the unanimous ballot.

XIV-3. ALTERNATE DELEGATES TO AMA

THE SPEAKER: Alternate Delegates to American Medical Association.

R. A. JOHNSON, M.D. (Wayne): I would like to place the name of a delegate, at the request of the Wayne delegation, Dr. Barrett. Dr. Barrett has been

a delegate here from Wayne County for a number of years.

THE SPEAKER: Dr. Barrett of Wayne has been nominated. Are there other nominations? There are two more vacancies to be filled.

DR. CATHERWOOD (Wayne): I would like to nominate Dr. Gorsline of Battle Creek.

THE SPEAKER: Dr. Gorsline's name has been nominated. There is still one more.

DR. BREAKEY (Ingham): I would like to nominate Dr. R. H. Denham of Grand Rapids.

DR. WALKER: I move the nominations be closed.

THE SPEAKER: We can't do that in this case. This election has to be done by ballot for this reason: These men's seniority is determined by the number of ballots they receive. Therefore, this particular thing will be voted by ballot. However, you may move to close the nominations if you wish to do that.

DR. WALKER: I move the nominations be closed.

(The motion was seconded.)

THE SPEAKER: Then, the Secretary will please prepare the ballots.

DR. HESS: If there are going to be three alternates and we vote on three men, they are all going to get the same number of votes.

THE SPEAKER: Not necessarily. There are different ways of doing it. (Cries of "draw it from a hat.")

If it is satisfactory to the House, the suggestion has been made that the names be drawn from a hat. Is that satisfactory to the House? (Agreed.) The first name drawn will be the first in seniority.

DR. HESS: I move we suspend the rules and By-Laws to make that possible.

DR. CATHERWOOD: I second that.

THE SPEAKER: I think that requires a two-thirds vote.

DR. HESS: Page 91, Section 7.

THE SPEAKER: A two-thirds vote is required to suspend the rules.

(The question was called.)

THE SPEAKER: All those in favor of suspending the rules, please say "aye"; opposed? The motion is carried and we will draw the names from the hat.

The Chair will appoint Dr. Hess to help us.

(The names were put in a hat and drawn out by Dr. Hess.)

DR. HESS: Dr. Denham is the first name drawn out of the hat. Dr. Barrett is the second. Dr. Gorsline is the third.

THE SPEAKER: The seniority of the alternate delegates will be as follows: Dr. Denham, Dr. Barrett and Dr. Gorsline.

XIV-4. PRESIDENT-ELECT

The next officer to be nominated is the President-Elect. Nominations are now in order for that office.

A. B. SMITH, M.D. (Kent): I wish you to accept my ensuing statements as expressive of the statement of the entire medical profession of Kent County. I am happy to have the honor and the privilege of submitting the name of one of my eminent colleagues and friends in nomination before this House. I am also happy, as I am sure you all are, to see long, faithful and ardent service in any cause rewarded.

I am happy to be able to assure you that the man of whom I speak fulfills all the above qualifications and many more. We, in the Kent County Medical Society have known him and been socially and professionally associated with him, since 1913. We have all learned to love him personally, and respect him professionally. He has served loyally in the cause of organized medicine and that includes his presidency of our medical society. Concurrently, he served on committees for the state medical society and is a member of the House of Delegates from Kent.

In 1935 he was appointed to the Council of the State Medical Society by Dr. Richard Smith, then president,

in which organization he served on the Executive Committee for several years. He also served as chairman of the Finance Committee of the Council. He has held membership on the Board of Trustees of Michigan Medical Service since its inception and long before its operations as a going concern. That is another of his activities in the interests of organized medicine which must be mentioned.

Finally, he is at present, Chairman of the Council of the Michigan State Medical Society, which office he has held for the past year. Mr. Speaker, I contend that few of our members, if any, have had the fully rounded experience in matters relating to the welfare of Michigan this man has enjoyed. I advocate and recommend, I am sure, with your approval, this man who has had such a vast store of experience in the immediate future administration of medical affairs.

I consider it an honor, particularly tinged with a high degree of personal pleasure to present to this assembly in nomination for President of the Michigan State Medical Society, Vernor M. Moore, M.D., of the Kent County Society, the city of Grand Rapids.

DR. LUCE: I wish to second the nomination.

THE SPEAKER: Are there any other nominations? If there are no other nominations, the Chair will entertain a motion.

R. J. ARMSTRONG, M.D. (Kalamazoo): I move the nominations be closed and the Secretary be instructed to cast the unanimous ballot.

A. E. STICKLEY, M.D. (Ottawa): I second it.

THE SPEAKER: Is there any discussion? All in favor of the motion say "aye"; opposed? The motion is carried. The Secretary will cast the ballot.

THE SECRETARY: I cast the unanimous ballot.

XIV-5. SPEAKER OF THE HOUSE

THE SPEAKER: The next office is the Speaker of the House of Delegates. I will ask the Vice Speaker to assume the Chair.

(The Vice Speaker assumed the Chair.)

THE CHAIRMAN: Nominations are now in order for the office of Speaker.

L. W. HULL, M.D. (Wayne): On behalf of the Wayne County delegation, I wish to place the name of our present Speaker, P. L. Ledgwick, M.D., in nomination for this office. Anything I might say about our present Speaker would be just superfluous.

THE CHAIRMAN: I wish the privilege, as the Vice Speaker at this time to say something but as you know it is against the rules for a speaker to comment on resolutions and nominations. However, I will listen for further recommendations at this time for Speaker of the House of Delegates. If there is none— Is there a second?

(The motion was severally seconded.)

DR. HESS: I move the nominations be closed and that the Secretary be instructed to cast the unanimous ballot for Dr. Ledgwick as our Speaker.

DR. STICKLEY: (Ottawa): I second it.

THE CHAIRMAN: All in favor of the motion respond by saying "aye"; opposed? Carried.

THE SECRETARY: I cast the unanimous ballot.

(The Speaker reassumed the Chair.)

THE SPEAKER: Thank you very much for your continued confidence and help. We have one or two other things to do and then we are going to have some of these men come to the front.

XIV-6. VICE SPEAKER

Nominations are now in order for Vice Speaker of the House.

DR. WALKER (Wayne): I would like to nominate for the office of Vice Speaker, the present Vice Speaker, Dr. E. A. Oakes, who has successfully carried on his job in the past. I so move.

THE SPEAKER: The name of Dr. Oakes has been nominated. Are there any other nominations?

DR. DARLING: (Wayne): I move the nominations be closed and the Secretary be instructed to cast the unanimous ballot.

C. A. PAUKSTIS, M.D. (Mason): I second that.

THE SPEAKER: You have heard the motion that the nominations be closed and the Secretary instructed to cast the unanimous ballot for Dr. Oakes as Vice Speaker. All in favor of the motion say "aye"; opposed? Carried. Dr. Oakes! (Applause.)

Now, at this time, the Speaker would like to ask Dr. Henry Luce, Dr. Claude Keyport and any of the other Past Presidents in this group to please escort the President-Elect to the rostrum. I would like to have all Past Presidents help in this present duty.

(The audience arose while the Past Presidents escorted the President-Elect to the rostrum.)

THE SPEAKER: I have the privilege of presenting Dr. Moore as the President-Elect of the Michigan State Medical Society. May I be the first to congratulate you and ask you to say a few words?

PRESIDENT-ELECT MOORE: Mr. Speaker and Members of the House: The hour is late and I will not keep you. I just want to express my deep sense of appreciation for this honor which you have sought to confer upon me. At this time I want to take the opportunity of expressing to you my appreciation of the work that the Council has done in this and in previous years I have been associated with it. I think most of you realize the time that is spent by the Council in carrying on the work of the Society between the meetings of the House of Delegates. We also have appreciated that whenever the Annual Meeting comes around, we are always glad to have certain problems laid in your lap for solution. Sometimes they are returned back to us with interest, but that is as might be expected.

I have a year to get adjusted to this new job and I hope that I may measure up to the confidence you have placed in me in electing me. Again, I want to thank you very much. (Applause.)

THE SPEAKER: It has been called to my attention by some of our members that this creates a vacancy in the Fifth Councilor District of which Dr. Moore has been Councilor, and it will now be necessary to elect a Councilor to fill out his unexpired term for the period of two years. The term expires in 1946. There is a rule, you know, in the By-Laws, that the Councilor has to be nominated by somebody from that district, so they are talking it over now and we will wait.

I would like now, at this time, as one of the last duties on our agenda, to thank all those who helped make the meeting of the House of Delegates such a success. That means every delegate who came, and especially the ones who worked on the committees and especially the ones who were so patient through all the routine stuff we have to do. They make my job easy.

I want also to thank all those I worked with during the year. All the things said about Dr. Moore are true, and there are many things unsaid that would add to his laurels. Also, in working with the other members of the Council, they are a most understanding group. I think you have seen enough of me to know I am frequently in hot water and they are very, very kind and generous.

I also want to thank the Executive Secretary's office and Dr. Foster. If you have never worked on that Council or been in one of those offices, you have no idea of the work that goes through them. It is tremendous and it is handled in a most efficient and helpful manner to all those concerned. It is a pleasure to work with them.

That is about all I have to say, except once more I want to thank you very much for overlooking the errors and again making me Speaker of the House.

Dr. Oakes, would you like to tell them how you feel?

Well, I guess there is nothing else except the election of the Councilor.

XIV-7. COUNCILOR 5th DISTRICT

A. V. WENGER, M.D. (Kent): I wish to put in nomination the name of A. B. Smith of Kent.

DR. STICKLEY (Ottawa): I second that.

THE SPEAKER: Are there any other nominations?

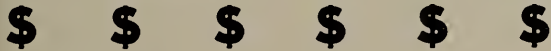
DR. O'MEARA: I move the nominations be closed and the Secretary instructed to cast the unanimous ballot for Dr. Smith.

W. S. GONNE, M.D. (Wayne): I second the motion.

THE SPEAKER: All in favor of the motion please say "aye"; opposed? Dr. Smith is Councilor of the Fifth District then, until 1946.

That completed our agenda and the Chair will now entertain a motion to adjourn.

(Upon motion duly made and seconded, it was voted to adjourn. The meeting adjourned at eleven-twenty o'clock.)



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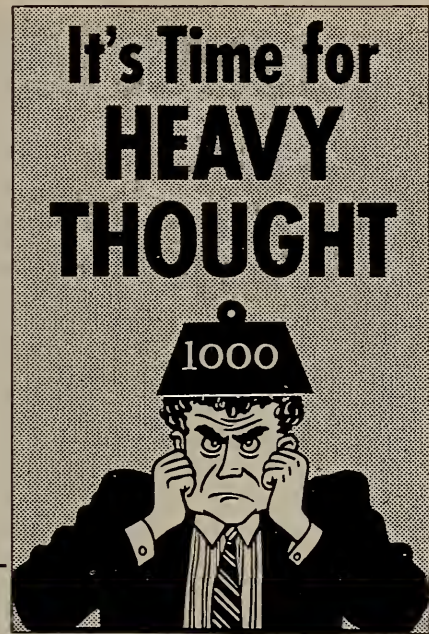
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Woman's Auxiliary

MID-YEAR BOARD MEETING

Mrs. Horace French, president, and Mrs. Lloyd Harvie, president-elect, reported on the national mid-year conference, which they attended in Chicago, November 16 and 17. They announced the Juvenile Delinquency project recommended by the national organization for State and County Auxiliaries. Dr. H. L. Kretschmer, president of the American Medical Association, in his explanatory remarks, stresses prevention of delinquency and its medical as well as social implications. The Auxiliaries may sponsor this project through the many local agencies already set up in the community. Dr. Roger Lee, president-elect in the American Medical Association, reported on Postwar Medical Service for the returning medical officers. The questionnaire sent out to 60,000 physicians, asking the wishes of the returning men in future education, indicated that the majority want a year or more of training on their return. About 10 per cent of 18,000 replies show a desire to stay in Government Service. A bureau is being set up in Chicago, AMA headquarters, which will provide information to discharged physicians concerning available facilities for practice of medicine in many communities and will promote better distribution of doctors in the United States, through co-operation of State and County Societies. The public is much more aware of the need for physical conditioning today. Dr. Morris Fishbein stressed that this program should be a venture in democracy rather than group regimentation. Dr. W. W. Bauer, Director of the Bureau of Health Education of the AMA, announced the radio series "Doctors Look Ahead," January 6 to June 30. This program can be heard Saturday afternoons at three or four o'clock. Mrs. Harvie mentioned especially the series of electrically transcribed radio programs or "platters" available to all Auxiliaries by writing Dr. W. W. Bauer, c/o AMA, Chicago. Return postage on records is the only expense involved. The "platter" series, "Before the Doctor Comes," is made up of sixteen ten-minute programs; "Dodging Contagious Disease" is made up of twelve ten-minute programs. Twelve fifteen-minute programs are in the series "Live and Like It," while "Medicine Serves America" has ten fifteen-minute interviews.

WAYNE COUNTY

The Wayne County Auxiliary of Detroit presented a unique program in panel form with the subject, "Youth Problems in a Large City." The participants in the panel were: Moderator—Mrs. Warren B. Cooksey; representing the Churches—Rev. Olert; Representing the Juvenile Court—Judge Healy; representing the Woman's Division of the Detroit Police Department—Miss Eleanor Hutzel; representing Education in the Secondary Schools, Prof. Earl Kelly of Wayne University.

The discussion was along the following lines—we are not expanding our educational and recreational facilities speedily enough to take care of our youth. Youth must have more opportunity to join organizations taking care of their leisure time especially in areas of high tension. Seeing groups of young people congregated on street corners is not a pleasing sight, and this presents a question of youth centers hoping that in them we may find the solution but, like picking up all dogs on the streets and putting them into a dog pound, this is not the answer. However, youth centers do have their place and many under the proper supervision have been very successful.

Sixteen years of age can be the problem age. Truancy has increased. Our classrooms are overcrowded and still our educational facilities are inadequate to cope with our vital youth problems.

The economic status of our delinquent youth makes very little difference—we find the same situation in both the poor families and the rich families. We are too materialistic. There is too great a span between Church and State. We should discontinue this "debunking" method. Our children have an attitude of "know it all." One panel member said—"We should not stop reading fairy stories." If the children had acquired a taste for good literature, wholesome stories of adventure and imagination early they would not have any difficulty reading them later. On the contrary, they have been educated to like movies, comic books, funny pages and scandal headlines, and that seems to satisfy their minds. What is the home doing to encourage good reading habits? Also—are our homes giving our youth the sense of security they so sorely need? Divorces undermine the child's security. Marriages ending in divorce are very often quick legal marriages and husband and wife have not known each other sufficiently to be psychological marriages. Seven out of ten war marriages in Britain have this termination because of this insecurity.

Religion plays a very important role in delinquent youth problems. Statistics show that 80 per cent of our delinquent youth come from homes where there is no religion. Children are great imitators, and we should not be ashamed to pray and practice our religion in our home. First of all, we must educate the parents to realize their responsibility toward bringing up their children. As individuals we must keep informed on all child labor laws, recreational places; help find and suggest good leadership for youth groups; keep an open mind and an attentive ear to all requests and projects in which youths are interested and wish to participate.

Our homes should be made as attractive as possible. In planning with youths for their future, they will feel a sense of security which will not be superficial.

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What's What

Seventy (70) doctors of medicine killed in action in World War II were listed in *JAMA* in 1944. In addition, 113 others died in military service during the past year.

* * *

Personals

William B. Hubbard, M.D., Flint, is quoted in Gifford's new edition on Ocular Therapeutics for his research on eye burns.

* * *

A. S. Brunk, M.D., President of the MSMS, addressed the Chippewa-Mackinac County Medical Society at Sault Ste. Marie on January 11.

* * *

L. S. Woodworth, M.D., President of the Michigan Hospital Association and Assistant Superintendent of Harper Hospital, Detroit, has left Michigan to become Superintendent of the Massachusetts Memorial Hospitals in Boston. Rev. John L. Ernst of the Evangelical Deaconess Hospital, Detroit, succeeds Dr. Woodworth as President of the Michigan Hospital Association.

* * *

Karl A. Menninger, M.D., of Topeka, Kansas, President of the Menninger Foundation, addressed the Michigan Society of Neurology and Psychiatry in Detroit, November 30, on the subject "Psychiatry in Medical Education." On January 25, 1945, Percival Bailey, M.D., Professor of Neurology and Neurosurgery at the University of Illinois College of Medicine, Chicago, will address the Society on "Cerebral Architectonics."

* * *

Samuel H. Camp, founder of S. H. Camp & Company of Jackson, died after a long and useful life, in December, 1944. Mr. Camp was born and lived for all of his seventy-three years in Jackson, Michigan. He founded the company that bears his name in 1908, primarily to meet the requirements of doctors of medicine in their practice. His credo was "Education before sales" and led to the Transparent Woman public health educational exhibit and the inauguration of "National Posture Week."

L. Fernald Foster, M.D., Secretary, MSMS, spoke at the County Secretaries' Conference of the Medical Society of the State of Pennsylvania, at Harrisburg, Pa., on January 11 on "Realism in Extension of Public Relations." He also was discussant in the symposium of January 12 on "Group Medical Care Plans."

* * *

The Wartime Graduate Medical Meetings Committee is continuing its weekly staff conferences at Percy Jones General and Convalescent Hospital, Battle Creek. B. F. Johanson, D.D.S., of Battle Creek spoke on "Immediate Dental Insertion" on February 5; Harry M. Weber, M.D., of Rochester, Minn., spoke on "The Roentgenologic Contribution to the Diagnosis of Colitis," on February 12; Capt. A. W. Frisch, MC, of Percy Jones Hospital, featured the February 19 meeting with a report on "Recent Advances in Virus and Rickettsial Diseases"; and Warren H. Cole, M.D., Chicago, addressed the conference of February 26 on "Surgical Diseases of the Stomach."

* * *

Radio Presentations

Radio presentations sponsored by the MSMS Radio Committee (Russell N. DeJong, M.D., Chairman) during January were as follows:

January 4—Dr. Robert L. Novy, Professor of Clinical Medicine in the Wayne University College of Medicine and President of the Michigan Medical Service: Prepaid Medical Care for the People of Michigan.

January 11—Dr. Ralph H. Pino, Assistant Professor of Clinical Ophthalmology in the Wayne University College of Medicine and Editor of the *Detroit Medical News*: Exploring the Medical Frontiers.

January 18—Dr. Bruce H. Douglas, Commissioner, City of Detroit Department of Health and Professor of Preventive Medicine and Public Health in the Wayne University College of Medicine: Health on the Home Front.

January 25—Dr. Marvin Schwartz, Instructor in Medicine in the Wayne University College of Medicine: The Diabetic and His Problems.

* * *

Miscellaneous

The Michigan Pathological Society held its bimonthly meeting at the Henry Ford Hospital, Detroit, on Saturday afternoon and evening, December 9. A seminar on "Lesions of the Liver" was conducted under the leadership of Harry Goldblatt, M.D., Professor of Experimental Pathology, Western Reserve University School of Medicine, Cleveland. Thirty-five members and guests were present. Dinner was served in the dining rooms of the hospital. Frank W. Hartman, M.D., acted as host.

At the annual business session of the Society the following officers were elected for the ensuing year: S. C. Howard, M.D., Ann Arbor, president; A. L. Amolsch,

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M.D., Detroit, president-elect; S. E. Gould, M.D., Eloise, secretary-treasurer.

* * *

The Chicago Medical Society's Clinical Conference scheduled for February 27-28 and March 1, 1945, has been cancelled. This action was taken in order to co-operate to the fullest possible extent with the request of the Office of Defense Transportation and in the interest of the nation's war effort.

* * *

The fifth semi-annual refresher course in otolaryngology will be conducted by the University of Illinois College of Medicine at the College in Chicago, March 26 to 31, inclusive. The fee is \$50. For further information write A. R. Hollender, M.D., 1853 W. Polk, Chicago 12.

* * *

The National Society for the Prevention of Blindness announced a prize of \$500 for the most valuable original paper adding to existing knowledge about the diagnosis of early glaucoma or the medical treatment of noncongestive glaucoma. For further information write the Society at 1790 Broadway, New York City.

* * *

Senator Wagner has a new bill which would provide thirty days' medical care, including hospitalization, to anyone covered in the old-age pension system, the federal government paying the doctor's bill and the hospital bill direct. If funds collected by this method should prove adequate, there is a provision that medical or hospital care may be extended to 90 days. This phase is certain to stir up bitter controversy in Congress, and early approval is considered highly doubtful. The whole program, of necessity, would be costly; and payroll taxes would have to be doubled to keep the program functioning and build up reserves against future contingencies.—*Hospitals*, January, 1945.

* * *

The New People's Community Hospital at Eloise, Michigan, was opened on December 15 to serve war workers in that area. The project was sponsored by the Wayne County Medical Society which has been working on a three-point program of extension of medical facilities in the County for over two years. The seventy-nine-bed hospital is located in what was formerly "Building B" of Eloise Hospital and Infirmary. Remodeling costs were approximately \$125,000 and equipment cost \$36,000. Of this total, \$15,000 was raised by the Hospital from voluntary contributions, the balance being paid by the federal government.

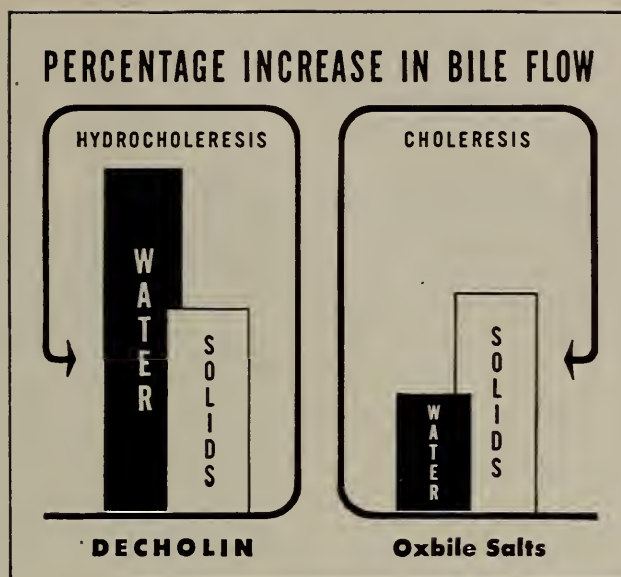
In addition to the People's Community Hospital, the Wayne County Medical Society also aided in the establishment of the new Wayne County Department of Health.

* * *

Last November, Montana osteopaths presented Initiative No. 48 to the voters of that state. As drafted, this proposal would have given osteopaths unlimited surgical rights and would have permitted them to practice in any tax-exempt hospital.

The measure suffered a crushing defeat, 108,882 to 36,676 votes. Fifty-four of the state's fifty-six counties voted against the measure.

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To the Editor:

"The war is a long ways from being over!"

That, most everyone agrees, is unfortunately true. Though we are tasting victory in all our war theaters, the road to final surrender of our enemies still looms lengthy and rough. Help is still needed from all sides and all hands—and particularly from the medical profession.

The enlistment of many more doctors rates a triple-A priority by the U. S. Navy today. Their skills and talents are required on ships, at advanced bases and continental shore stations in ever-increasing numbers. The lives of countless thousands of our men in blue are and will be dependent on doctors who are close at hand, on doctors who are thus making a tremendous contribution to humanity and are speeding victory.

In seeking the enlistment of hundreds of doctors today, the Navy is inviting the applications of physicians, surgeons and specialists in a very wide range of practices and ages. If physically qualified, most of those who are enlisted will be eligible for assignment at sea or at bases located in many parts of the world, though many vacancies also exist in Naval hospitals and activities in the United States.

Most doctors under thirty-eight years of age who have been made available are already in uniform. Men in this classification are assigned either afloat or ashore.

Doctors up to fifty-five years of age are now being considered by the Navy for direct commissions. They are expected for unlimited duty either ashore or afloat.

Broadened Navy procurement regulations also permit the enlistment of specialists and general practitioners up to 60 years of age for limited duty; they generally will be assigned within the United States. In some instances they may serve at overseas bases or stations.

General education and experience qualifications include graduation from an accredited medical school with at least one year of internship in an approved hospital. Of course, applicant must be duly licensed to practice medicine and be a member of a local or state medical society. Waivers will be granted on various physical conditions.

When accepted, the doctor's rank as a Naval Officer will be determined by age, education and background.

Women also are being accepted in the above classifications and present Navy regulations limit their duty within the continental limits of the United States.

Complete information regarding medical officers' commissions in the Navy may be obtained at the Office of Naval Officer Procurement, Book Bldg., 1249 Washington Blvd., Detroit. The Navy's need for medical officers is most urgent at this time; it believes you can qualify. Will you offer to serve?

D. F. Hoyt, Comdr. MC, USNR,
Senior Medical Officer

Dr. L. F. Foster
Michigan State Medical Society
2020 Olds Tower
Lansing, Michigan

Dear Dr. Foster:

Thank you very much for your nice letter of December 21.

I am indeed pleased to be advised of the action of the House of Delegates. It has been a pleasure for us to co-operate with our medical friends in connection with the Beaumont Memorial. My only regret is that, due to conditions, it has not been possible to push the undertaking along more rapidly.

Very truly yours,
(Signed) A. M. LESCOHIER
A. W. Lescoghier, President
Parke, Davis & Company, Detroit

December 22, 1944

L. Fernald Foster, M.D., Secretary,
Michigan State Medical Society
2020 Olds Tower,
Lansing, Michigan

It is with sincere gratefulness that I wish to acknowledge the honor conferred upon me by the House of Delegates of the Michigan State Medical Society.

I hope to remain of some little service professionally in spite of my unfortunate handicap, resulting from the stroke I sustained over two years ago.

Kindly extend to the House of Delegates my hearty appreciation of their kind action.

With my gratitude and the Season's Greetings to you, I am

Sincerely yours,
PAUL ROTH, M.D.
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Battle Creek, Michigan

December 22, 1944

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In Memoriam

PRESIDENT-ELECT VERNOR M. MOORE

Vernor M. Moore of Grand Rapids was born in Freeport in 1886 and was graduated from the University of Michigan Medical School in 1911. He located in Sparta, where he remained one year and then went to Grand Rapids where he was associated with the late William Northrup, M.D., for three years, then with the late Richard R. Smith, M.D. He opened his own roentgenology office in the Metz Building and for years was one of the outstanding radiologists of his community and the State. Doctor Moore served as president of the Kent County Medical Society in 1927. He was made president-elect of the Michigan State Medical Society in September, 1944, after ten years' service as a councilor of the State Society and one year as chairman of The Council. He was a member of the American Board of Radiology. He died unexpectedly December 30, 1944.

DIED IN MILITARY SERVICE

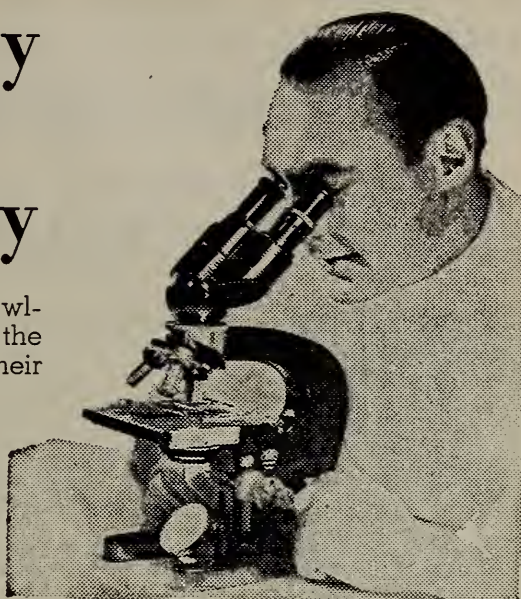
Herman M. Lord of Detroit was born September 6, 1911, in Pittsburgh, Pa., and was graduated from Wayne University College of Medicine in 1937. He interned at Grace Hospital 1936-1937 and at Woman's Hospital the following year. He entered the United States Army Medical Corps January 27, 1941, as First Lieutenant. His first assignment was at the Fitzsimmons General Hospital, where he taught enlisted personnel. He was promoted to Captain, sent to the Mayo Clinic in January, 1943, for a course in internal medicine and subsequently returned to Fitzsimmons for a course in hospital management. After a short period at Northington General Hospital, he was assigned to the 45th Field Hospital at Fort Bragg, N. C. This unit was activated in January, 1944, with Doctor Lord commanding one platoon, and was sent to England in February 1944. He entered France on D-4 Day and his field hospital was the first to land with full equipment. From the beaches of Normandy he was with the First Army at Cherbourg and through all the fighting in France. In August, 1943, he received his Majority. He accompanied the First Army to Belgium. Doctor Lord was seriously wounded by a burst of German shellfire, the night of October 21, 1944, and died on October 27, 1944.

Herbert J. Kaufman of Owosso was born in Owosso, on July 20, 1912. He was graduated from Wayne University Medical School in 1938. Following his graduation he located in Owosso until he entered the Medical Corps in July, 1942, with the rank of lieutenant. Later he was made a captain. His first assignment was to the Eye, Ear, Nose and Throat Department of the Station Hospital at Camp Cooke, California. He remained there six months and was transferred to the Eye, Ear, Nose and Throat Department of the Regional Hospital at Oakland, California, joining a unit that received the injured from the battle lines. Here he became ill and was sent to Hammond General Hospital, Modesto, California, where he died on November 20, 1944.

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Charles W. Case of Onsted was born December 3, 1869, at Canandaigua, N. Y., and was graduated from the University of Pennsylvania in 1899. Doctor Case located in Onsted in the spring of 1900 and practiced there until the time of his death. He had been on the staff of Bixby hospital in Adrian for many years. He died after a long illness, November 11, 1944.

William M. Donald of Detroit was born in Allensburg, Ontario, December 15, 1860, and was graduated from the Detroit College of Medicine in 1887. He practiced in Detroit for over fifty years. In 1939 he was elected to Emeritus Membership in the Michigan State Medical Society. Dr. Donald was a staff member of Receiving, Evangelical Deaconess, St. Joseph's Mercy, Alexander Blain, St. Mary's and East Side General Hospitals. He was a past president of the Wayne County Medical Society. Doctor Donald died on December 20, 1944.

Frederick M. Ilgenfritz of Kalamazoo was born June 10, 1879, at Monroe, and was graduated from the Detroit College of Medicine in 1903. Following his internship at Harper hospital in Detroit, he located in Kalamazoo. He was county physician for fifteen years, physician for the Consumers Power Company thirty-six years and at the time of his death was physician in the city schools and examining physician for selective service board No. 2. Doctor Ilgenfritz died November 15, 1944, after a brief illness.

Thomas C. Irwin of Grand Rapids was born in Alliston, Ontario, in 1866, and was graduated from the University of Toronto Medical School in 1891. He spent two years' postgraduate work in London, Dublin, Munich and Berlin. He then returned to America and opened his practice in Grand Rapids. He had been chief of staff of Blodgett Hospital for five years. He was active in medical circles as well as civic organizations. Doctor Irwin died December 8, 1944.

William Northrup of Grand Rapids was born in 1866 and was graduated from the University of Ontario Medical School in 1894. He began practice in Freeport. Subsequently he practiced in Clarksville, Remus and Alto, before locating in Grand Rapids. Doctor Northrup was a member of Blodgett Memorial Hospital staff for thirty years and had served as its chief. He had also been on the staffs of Butterworth and St. Mary's Hospitals. Although he had retired, he voluntarily resumed practice in the war emergency and served as physician at the Ionia Reformatory Hospital. He died December 8, 1944.

Robert H. Phillips of Lansing was born in Springfield, Ohio, in 1898 and was graduated from the University of Michigan Medical School in 1924. He served his internship in Ann Arbor and afterwards became associate instructor in medicine. Doctor Phillips opened his practice in Lansing in 1927. He served as Secretary of the Ingham County Medical Society in 1932. He died unexpectedly on December 19, 1944.

(Continued on Page 198)

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Wilfrid S. Picotte of Ishpeming was born in St. Paul l'Ermite, Quebec, Canada, on October 15, 1875, and was graduated from the University of Montreal in 1896. He opened his practice in Ishpeming in 1898. He was health officer for ten years, county physician for about the same length of time and surgeon for several public utility and insurance companies. Doctor Picotte died on December 12, 1944.

Vinton Rickerd of Charlotte was born June 4, 1869, in Ashland, Ohio, and was graduated from the Starling Medical School in 1896. He opened his practice in Charlotte, where he served that community for forty-eight years. He died December 27, 1944.

Cassius S. Sackett of Charlotte was born in Sunfield Township, Eaton County, June 7, 1857, and was graduated from the Eclectic College of Medicine at Cincinnati, Ohio, in 1894. He located first in Brookfield township, Eaton County, and later moved to Charlotte, where he practiced for forty-one years. He was president of Eaton County Medical Society in 1927-28-33. He was elected to Retired Membership of the Michigan State Medical Society in September 1940. Doctor Sackett died December 21, 1944.

Charles M. Swantek of Bay City was born in Danzig, Poland, May 28, 1873, and was graduated from Rush Medical School in 1894. Doctor Swantek had lived in Bay City for more than a half century and practiced there until he suffered a serious electrical shock when answering a call in March, 1920. He was elected to Retired Membership in the Michigan State Medical Society in September, 1941. He died December 29, 1944.

W. Ellwood Tew of Bessemer was born in Lapeer, September 7, 1885, and was graduated from the University of Michigan Medical School in 1903. He practiced in Niles and Boyne City before locating in Bessemer thirty years ago. For ten years he was a member of the Michigan State Board of Registration in Medicine. He was president of Gogebic County Medical Society in 1931 and Secretary at the time of his death. Dr. Tew was prominent in many community enterprises. He died December 25, 1944.

Charles B. Toms of Newberry was born in 1875 and was graduated from the Wayne University College of Medicine in 1902. He was assistant superintendent of the Newberry State Hospital for many years. He served as president of Luce County Medical Society in 1933-34. He died December 26, 1944.

William H. Veenboer of Grand Rapids was born in Grand Rapids in 1878 and was graduated from the University of Michigan Medical School in 1903. After one year of practice in Norway, Michigan, he located in Grand Rapids. Doctor Veenboer was on the staff of Butterworth and Blodgett Hospitals. In 1921 he received his Fellowship in the American College of Surgeons. He died December 21, 1944.

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

SURGERY OF THE HAND. By Sterling Bunnell, M.D., Honorary Member of American Academy of Orthopedic Surgeons, Member of American Association of Plastic Surgeons and of American Society of Plastic and Reconstructive Surgery, Licensee of American Board of General Surgery and Plastic Surgery. 712 pages with 597 illustrations. Philadelphia: J. B. Lippincott Company, 1944.

In this age of industrial surgery and its countless thousands of hand injuries every day all over the country, there has long been a need for a complete treatise on all types of hand pathology. Dr. Bunnell in his *Surgery of the Hand* has thoroughly satisfied this need and in doing so has created a masterpiece. His book is all-inclusive on anything pertaining to the hand, yet it is written simply, minutely, and concisely.

While much unnecessary history and other material is omitted for a welcome change, yet all of the multitudinous pathological changes of the hand are covered so thoroughly from every angle that bad hand surgery would be rather impossible to do for anyone following the text even fairly closely. The illustrations are beautifully clear and the section on "Tendon Repair" alone makes the book worth while. No practicing physician doing any amount of hand surgery can afford to be without this book on his shelf.

(Continued on Page 202)

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A TEXTBOOK OF PATHOLOGY: By Robert Allan Moore, Edward Mallinckrodt, Professor of Pathology, Washington University School of Medicine, St. Louis, Mo. 1338 pages with 513 illustrations, 34 in colors. Philadelphia and London: W. B. Saunders Company, 1944. Price \$10.00.

Dr. Moore has a grasp of pathology that makes this subject one of living interest in the study of medicine and the practice of the art. Of old, we were taught pathology as a science, giving the study of the tissues and organs, and incidentally telling something of the disease that was involved. But this text changes that entirely. Part I discusses general pathology divided into disturbances of metabolism of proteins, carbohydrates, lipoids, minerals, the fluids of the body, disturbances in the fluidity of the blood, growth and degeneration of cells, inflammation, repair, healing and tumors. Part II is concerned with diseases caused by living agents, grouped according to portal of entry, the skin, the air, exogenous or hematogenous, the alimentary tract also gastrointestinal, venereal, and miscellaneous infections. Part III covers diseases caused by physical agents and Part IV, those caused by chemical agents. Diseases related to pregnancy, those caused by deficiencies and those of unknown or obscure cause are each grouped by themselves. The pathological discussions of the specific diseases is clear and concise, sometimes sketchy, but this book cannot be expected to be a complete discussion of the minute pathology of all the diseases of the special sections of the body. This text is a clear and explicit reference in the study of medicine, and in its practice.

ENDOCRINOLOGY. A Brief Review for Physicians. By J. H. Hutton, M.D. Prepared for the Illinois Department of Public Health with the co-operation of the Illinois State Medical Society. Circular No. 177, State of Illinois, January, 1944.

Endocrine disorders are widespread, but comparatively little understood, and for that reason the Department of Public Health, co-operating with the State Medical Society has prepared this pocket-size, paper-covered booklet

(Continued on Page 204)

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to bring into co-ordination the salient facts about these diseases, their relations and treatment. There are chapters on the pituitary, the pineal, the thymus, the parathyroids, the thyroid, the adrenals, the gastro-intestinal tract, and a chapter each on the female and the male endocrinology. The discussions are lucid, timely and outstandingly helpful. Myxedema, Addison's disease, prevention of pregnancy accidents in diabetes, gives one a sample of the conditions studied.

HEART DISEASE. An Elementary Reference for Physicians. By Robert S. Berghoff, M.D., F.A.C.P., Clinical Professor of Medicine, Loyola University School of Medicine. Published by the State of Illinois, Department of Public Health, under the Auspices of the Post-Graduate Committee of the Illinois State Medical Society. Circular No. 176, January, 1944.

The exigencies of war have prompted this elementary outline of heart disease for the use of the average doctor in private practice who is too hard pressed with his own and his confrère's work. All the common forms of heart disease have been abstracted briefly. The prevailing forms of disease at various ages are stressed, and diagnosis and treatment outlined. It is mainly a guide, but a very-useful one. This is a pocket-size, paper-bound book, very handy, and well executed.

TABER'S DICTIONARY OF GYNECOLOGY AND OBSTETRICS. By Clarence Wilbur Taber, Medical Editor and author of Taber's Cyclopedic Medical Dictionary, Taber's Condensed Medical Dictionary, et cetera, with the collaboration of Mario A. Costello, M.D., F.A.C.S., Assistant Professor of Obstetrics, Jefferson Medical College, Gynecologist to St. Mary's and St. Agnes' Hospitals. Illustrated. Philadelphia: F. A. Davis Company, 1944.

This is a thumb-indexed dictionary, two columns, with the key word in black-face type, and the text in
(Continued on Page 206)

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large type. Pronunciation is given with sufficient outline of discussion, covering synonym, etiology, pathology, symptoms and treatment under the disease headings. Symptom headings are defined or described briefly. Where applicable, there is also included a paragraph on the General Duties of the Nurse. Under "Delivery" are listed fifty-two short paragraphs of duties for the "roust" nurse, and thirty-two for the "sterile" nurse. The book has no page numbers, but has numbers for each letter as well as the key word at the top of each page. It is a handy and accurate dictionary of a special medical field.

INTERN'S HANDBOOK, A Guide, especially in Emergencies, for the intern and the Physician in General Practice. By Members of the Faculty of the College of Medicine, Syracuse University, under the direction of M. S. Dooley, A.B., M.D., Professor of Pharmacology, and Maynard E. Holmes, M.D., F.A.C.P., Professor of Clinical Medicine. Third edition. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944. Price \$3.00.

Every practitioner of medicine must understand certain relationships, which are inadequately studied in his student days—the intern, the hospital, the practitioner, the public. These form the subject matter of the first chapter. The relation of medicine to the social services is suggested, and a chapter on medical jurisprudence, contracts, relation to the staff of the hospital. Autopsies, wills, mental cases are discussed. The book itself then takes up fundamental phases of the specialties and their approach to medical care. The bulk of the book takes up diseases and disease conditions in their groupings and classifications, their diagnosis and treatment. There are rules to follow, and rules to avoid trouble. There are outlines of treatment with dosage given in detail. This is a comprehensive handbook, and a valuable one.

MILITARY MEDICAL MANUALS—Manual of Clinical Mycology: Prepared under the Auspices of the Division of Medical Sciences of the National Research Council. 348 pages with 148 illustrations. Philadelphia and London: W. B. Saunders Company, 1944. Price \$3.50.

This is another of the series of Military Medical Manuals sponsored by the National Research Council and covers a most interesting and important group of diseases—fungus infections. These diseases are studied as to geographical distribution, source of infection, symptomatology and treatment. Many illustrations are given of striking conditions, or those more easily diagnosed by familiarity with appearance. Mycology is becoming more and more a common disease entity, and therefore of increasing interest to the general practitioner. This manual is indispensable.

LEAD POISONING. By Abraham Cantarow, M.D., Associate Professor of Medicine, Jefferson Medical College; Assistant Physician, Jefferson Hospital; and Max Trumper, Ph.D., Lt. Commander, H-V(s), U.S.N.R.; Naval Medical Research Institute, Bethesda, Md. Baltimore: The Williams & Wilkins Company, 1944. Price \$3.00.

Lead poisoning is one of the first and most frequent industrial hazards. The disease has been known from earliest times, as lead was one of the first-known metals. Much has been written on the subject, and this book brings into easily obtainable form the best-known information on the subject. It is an exhaustive and authoritative treatise, and of the essential texts for the industrial physician and surgeon.

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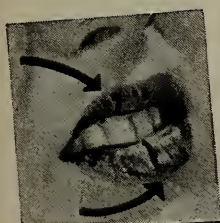
ARTHRITIS AND ALLIED CONDITIONS. By Bernard I. Comroe, A.B., M.D., F.A.C.P., Associate in Medicine, University of Pennsylvania, Senior Ward Physician and Chief of the Arthritis Clinic, Hospital of the University of Pennsylvania. Third Edition, Enlarged and Thoroughly Revised. Illustrated with 329 Engravings. Philadelphia: Lea & Febiger, 1944. Price \$12.00.

This book is especially prepared for the general practitioner and emphasizes the salient points in the diagnosis, differential diagnosis, and treatment of arthritis and all its allied conditions. The role of penicillin, and the sulfonamides is given, as also the use of gold therapy. A diagnostic digest of the arthritis problem is given. Diagnosis is stressed, and treatment is applied in systematic methods. A black line box is given with the diagnosis at the top, and under that in 1, 2, 3 order is listed the things to do for the patient. These are then elaborated in the text. Emphasis and special attention is indicated by black face type and by italics. One chapter is given of mistakes frequently made in the diagnosis and handling of patients with arthritis and allied conditions. 238 such mistakes are listed. These "mistakes" alone are worth the value of the book. Study

and careful attention to suggestions given will well repay its owner.

TEXTBOOK OF MEDICAL TREATMENT. By various authors. Edited by D. M. Dunlop, B.A., M.D., F.R.C.P. (Edin.), M.R.C.P. (Lond.); Professor of Therapeutics and Clinical Medicine, University of Edinburgh; Physician, Royal Infirmary, Edinburgh; L. S. P. Davidson, B.A., M.D., F.R.C.P. (Edin.), F.R.C.P. (Lond.), Professor of Medicine and Clinical Medicine, University of Edinburgh, Physician, Royal Infirmary, Edinburgh, and J. W. McNee, D.S.O., D.Sc., M.D., F.R.C.P. (Edin.), F.R.C.P. (Lond.), Physician H.M. the King of Scotland, Regius Professor of Practice of Medicine, University of Glasgow, etc. Third Edition. A William Wood Book. Baltimore: The Williams and Wilkins Company, 1944.

The authors have prepared a textbook of treatment that covers rather well the whole field of medicine. Diseases or groups of diseases are considered from the standpoint of treatment only—first the relief of pain, of symptoms, and the specific treatment so far as there is any. The treatment is geared to the patient, his condition, age and other characteristics. The text is full, clear and gives sufficient detail to be followed. This is a valuable book to be on the shelves of any practitioner who cares for sick people.



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Robert W. Strong, Publisher of the *Crawford Avalanche* of Grayling, Michigan, wrote a strong and courageous editorial in his weekly newspaper, February 22, entitled "A Better America, Not A New One." Answering the Michigan State Medical Society's request for permission to republish this excellent essay, Mr. Strong wrote, "The editorial is only a small gesture on the part of one small town editor who is proud of the fight that our medical men are making to save our country from the engulfing wave of government control. I sincerely believe that if every professional man stands up for the American way, we need not fear for our way of life."

Editor Strong's editorial follows:

Most of us have been so busy arguing over plans to provide a greater quantity of medical care to the people, that the all-important item of quality has been neglected. However, the attention of medical men has been centered on both quality and quantity.

One medical authority points out that the advance of medicine has not been halted in the United States in the war period, but rather has proceeded with an intensity that is the amazement of all of the other nations of the world.

We have seen the death rate for pneumonia among American troops drop from 28 per cent in World War I to a fraction of 1 per cent in this war. We have seen the death rate from meningitis drop from something like 80 per cent thirty-five years ago to 3 to 5 per cent at this time. And recently a physician at the Great Lakes Naval Training Station reported seventy-five consecutive recoveries from meningitis—not one death until the seventy-sixth case!

It has been said that opponents of revolutionary changes in our form of government seek a better America, not a new one. And that certainly applies to the medical profession. It opposes the sweeping away of a medical system that has brought such great benefits to the Nation. It believes that the system can be improved and the benefits retained. Its approach to new schemes rests on the simple query, Will they improve and extend medical service? If, through experiment and experience, they are found wanting, the doctors can be counted upon to make a last-ditch fight against them.

CALIFORNIA'S PROPOSAL FOR STATE MEDICINE

Governor Earl Warren of California has introduced a bill into the California Legislature for compulsory health insurance. He plans a 3 per cent payroll tax, equally divided between the employer and the employee figured on the first \$4,000 of annual income.

Benefits would include medical, surgical and hospital service (with some limitations) together with emergency dentistry as represented by extractions and oral surgery.

Warren's plan calls for free choice of physician, with a prohibition against a physician draw-

ing both a state fee and a private fee on the same case. A state schedule of maximum fees would be set up for each procedure and physicians must either accept that schedule as full payment or make arrangements with the patient to handle the case on a private basis with no part of the total fee coming from the state.

The California CIO has also introduced a bill much like Governor Warren's except that payment to general practitioners would be on a capitation basis of \$20 per year per patient. This bill, like the Governor's, would take 3 per cent payroll taxes. The California Medical Association estimates that the entire program will be underfinanced and that *payments to the doctor would necessarily be reduced considerably below existing fee levels.*

The C.M.A. has gone on record as being opposed to the governor's plan or any other compulsory health insurance plan so far presented to it. It has introduced a bill into the California Legislature which would encourage voluntary plans such as California Physicians Service, Blue Cross, and reputable insurance company health and accident programs.

The MSMS JOURNAL's California correspondent anticipates that the California Legislature will appoint an interim committee to study the whole problem and report back at the 1947 session.

MSMS COUNCIL'S ACTION RE EMIC APPROVED BY HOUSE OF DELEGATES

The 1944 MSMS House of Delegates adopted by unanimous vote the following resolution at its Annual Session in Grand Rapids, September 25-26, 1944:

"Whereas, The EMIC program was referred to The Council for study, and

"Whereas, A special committee of The Council was assigned to the task, and

"Whereas, Many meetings and conferences were held with representatives of the Children's Bureau, health authorities, specialist groups, general practitioners, hospitals and other interested groups, and

"Whereas, As a result, these alternatives were presented by The Council to the profession namely:

"(1) Sign the blanks to provide for hospital service, giving professional care gratis; or (2) Sign the blanks and accept the government fee for medical care; or (3) Decline to participate in the program, as physicians see fit—be it

"Resolved, That this action of the Council be approved."

(Continued on Page 218)



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(Continued from Page 216)

COUNTRY-WIDE CHILD HEALTH PLAN

A country-wide plan for maternal and child health services for all the population, which would key in closely with the postwar "health center" network recommended by the Pepper subcommittee on wartime health and education, was shown to be in process of formulation by a Children's Bureau announcement.

Dr. Martha Eliot, associate chief of the bureau, who has charge of far-reaching maternal and child health programs, stated that seventy leading physicians and professional workers, meeting in Washington as an advisory committee to the Children's Bureau, had endorsed "a nation-wide survey of personnel and facilities needed to assure health services to all mothers and children, which will be undertaken by the American Academy of Pediatrics, with the help of the Children's Bureau and the United States Public Health Service."

Chairman of the advisory committee which endorsed the survey were Dr. Nicholson J. Eastman, Professor of Obstetrics at the School of Medicine, Johns Hopkins University, and Dr. Henry F. Helmholtz, chief of the Pediatric Department of the Mayo Clinic, Rochester, Minn.

The advisory committee on maternal child health set up as its aim "a long-term program directed at lower maternal and child mortality and morbidity to an irreducible minimum" and advocated "the delivery of all women in good hospitals under the care of competent physicians."

SILVER STAR MEDAL AWARD

Captain Fred G. Swartz, Jr., Medical Corps, United States Army, from Traverse City, Michigan, for gallantry in action in Germany from 22 to 24 November, 1944. On November 22 to 24, Captain Swartz made several trips to forward positions of the battalion in order to aid in the evacuation of wounded. On November 22, 1944, with complete disregard for his personal safety, and in the face of heavy artillery, and small arms fire, Captain Swartz left his battalion aid station and went forward to plan the evacuation of the wounded. On this occasion, Captain Swartz personally helped carry wounded to the aid station, administered medical aid, and refused to rest until all wounded had been evacuated from the field of battle and properly treated. On November 24 Captain Swartz again led litter bearers through heavy enemy fire, to evacuate wounded at the

height of the battle, assisting the litter bearers in their task. Captain Swartz's courageous leadership and inspiring devotion to duty saved the lives of many men, exemplifies the highest traditions of the American medical officer in the performance of his difficult mission, and reflects the highest credit on himself and the military service.

MILWAUKEE ACADEMY OF MEDICINE

The scheduled speaker on the program for the December 14, 1944, meeting of the Milwaukee Academy of Medicine was Dr. Walter Judd, Congressman from Minnesota. Twenty hours before the meeting a measure came up demanding that Congressman Judd stay in Washington. The substitution of Jay C. Ketchum, Executive Director Michigan Medical Service, was a rabbit-out-of-the-box. To quote *Milwaukee Medical Times*: "The success of the switch was demonstrated by the great interest shown by the Society members in what Ketchum had to say. His talk was followed by a barrage of questions relating to professionally sponsored prepayment plans as they operate in Michigan, and in relation to our own surgical care. Professionally sponsored prepayment plans have proved themselves as an answer to the threat of socialized medicine. . . . This fact was brought home by Jay C. Ketchum when he addressed the members of the Society at their annual dinner. If the success of the Michigan Medical Service can be used as a barometer, it bids fair to bear out the truth of Ketchum's statement that 'a professionally sponsored program of this type is wholly practical and equally beneficial to doctors and patients, and is eagerly accepted by the public.'"

A MUSICAL PRESCRIPTION!

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RADIO STATION WJR, DETROIT

Fridays, 7:15 p.m., EWT (See Page 292)

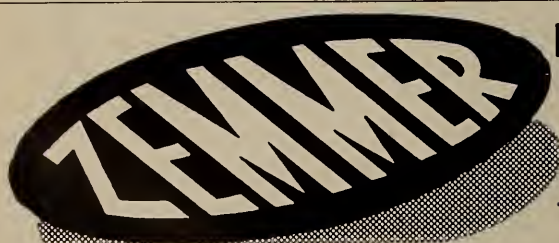
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MICHIGAN STATE MEDICAL SOCIETY

Third Annual Industrial Medical and Surgical Conference, Rackham Memorial Building, Detroit Thursday, April 4, 10:00 a.m. to 4:30 p.m., EWT

(See Page 288)

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PROCEEDINGS OF ANNUAL SESSION OF THE COUNCIL

Detroit, January 25, 26, 27, 1945

All twenty members of The Council of the Michigan State Medical Society were present at the Annual Session of January, 1945. For three days the Councilors deliberated over many important socio-economic problems and the business affairs of the Society. Each day's sessions represented 12 to 14 hours' work. Following are the highlights of the Council's actions:

Fred H. Drummond, M.D. of Kawkawlin was appointed by President A. S. Brunk, M.D. as Councilor of the Tenth District to take the place of R. C. Perkins, M.D. who resigned after long and valuable service to the Society, due to illness. Other elections included the Secretary, Treasurer and Editor with the incumbents, L. Fernald Foster, M.D., Bay City, Wm. A. Hyland, M.D., Grand Rapids, and Wilfrid Haughey, M.D., Battle Creek, being returned to their respective posts.

A testimonial scroll to the late Vernor M. Moore, President-Elect of the Michigan State Medical Society, who died suddenly on December 30, 1944 was authorized.

The Annual Reports of the Secretary, the Treasurer, the Trustee, and the Editor, as well as the Reports of Council Committees were submitted. Also monthly reports of the following MSMS Committees were presented: Postgraduate Medical Education, Postgraduate Foundation, Cancer Control, Physical Rehabilitation, Mental Hygiene, Industrial Health, and Radio. The thanks of The Council were extended to these and other active Committees of the Society for their progressive work in behalf of medical science and the profession.

The annual audit of the Society was approved, and budgets for 1945 were adopted. The Council retained J. Joseph Herbert, LL.B., Manistique, as General Counsel to perform all legal services for the Society.

Uniform Fee Schedule

The Council approved the recommendation of its Medical Advisory Committee on Physical Rehabilitation that a uniform medical and surgical fee schedule, to apply to all governmental agencies, be adopted by the State Society; a special committee to develop this schedule was appointed: R. L. Novy, M.D., Detroit, A. B. Smith, M.D., Grand Rapids, C. E. Toshach, M.D., Saginaw, Frank Van Schoick, M.D., Jackson, and E. R. Witwer, M.D., Detroit.

The Council authorized a new radio program

over station WJR, Detroit for twenty Fridays from 7:15 to 7:30 p.m., this to be a live program (not transcribed).

Veterans' Readjustment Program

In connection with the MSMS Medical Veterans' Readjustment Program, created by the 1944 House of Delegates, The Council instructed that a Counsellor and Advisor—a doctor of medicine—be selected as soon as possible, and if feasible that his offices be established in the David Whitney House, Detroit; further that a committee of practitioners, having several years' experience, be appointed to guide and counsel with the Advisor, this committee to cover all areas of the state.

A Special Contact Committee with the Association of Welfare Boards and Boards of Supervisors was appointed with G. L. McClellan, M.D., Detroit, as chairman.

The Veterans Administration's proposed contract with private hospitals for the care of veterans was given serious consideration, especially a clause covering the practice of radiology and laboratory work which appears to represent the practice of medicine by hospitals. The Council went on record as approving the care of veterans at home by their family physicians, and instructed its General Counsel to study the Veterans Administration's proposed contract.

Current plans in Washington, D. C., and elsewhere for compulsory health insurance and political control of medical practice were thoroughly discussed; alternatives and antidotes were considered. The astonishing success of Michigan Medical Service was outlined by its President R. L. Novy, M.D., Detroit, who presented MSMS President Brunk with a check for \$17,544.45 covering reimbursement in full of the original organizational expenses of the medical service corporation. The selling job of the Michigan medical profession—to offer *through private means and voluntary methods* complete health security to all the people of the nation—was stressed by John F. Hunt of Foote, Cone and Belding, Chicago, a guest at one of the five meetings of The Council. The Council went on record urging all Michigan doctors of medicine to present to the people and to physicians in other states the success story of Michigan Medical Service, that our membership be collectively and individually responsible for spreading information concerning Michigan Medical Service and Michigan Hospital Service.



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MSMS COUNTY SECRETARIES CONFERENCE

More than 175 attended the Annual County Secretaries' Conference and "School of Information," sponsored by the Michigan State Medical Society and held at the Book-Cadillac Hotel, Detroit, on January 28. Unanimous was the praise for an intensely interesting and enlightening program over which T. Y. Ho, M.D., St. Johns, presided.

"First Things First" was presented by W. W. Bauer, M.D., Chicago, Director of the Bureau of Health Education, AMA. "The Selling Job of the Michigan Medical Profession—What Must be Done NOW" was outlined by John F. Hunt, Chicago, Executive of Foote, Cone & Belding which conducted the Michigan Survey of Public Opinion last autumn.

"The Program and Objectives of the Michigan Physicians Committee" was explained by Edward F. Stegen, Chicago, Associate Administrator, National Physicians Committee.

"The Proposed Amendment to the Constitution of the State of Michigan" was presented by Professor Paul D. Bagwell, East Lansing, Head, Speech Department, Michigan State College.

"The Work of the Washington Office, Council on Medical Service and Public Relations" was outlined by Joseph S. Lawrence, M.D., Washington, D.C., Director, Washington Office, Council on Medical Service and Public Relations, AMA. "The Physical Rehabilitation Program of the Federal Government" was explained by E. F. Sladek, M.D., Traverse City, Chairman of The Council, Michigan State Medical Society.

An Exhibit on "Tropical Diseases" was presented by the Committee on Scientific Exhibits, AMA, with Thomas G. Hull, Director, in personal charge.

G. B. Saltonstall, M.D., Charlevoix, Secretary for many years of the Northern Michigan Medical Society, was elected chairman for the ensuing year.

The thirty-two County Secretaries present at the Conference were: U. M. Adams, M.D., Cass; J. K. Altland, M.D., Barry; E. B. Andersen, M.D., Dickinson-Iron; Helen S. Barnard, M.D., Muskegon; E. W. Blanchard, M.D.; Sanilac; A. L. Callery, M.D., St. Clair; E. S. Carr, M.D., Chippewa-Mackinac; R. C. Conybeare, M.D., Berrien; C. C. Corkill, M.D., St. Joseph; Ray M. Duffy, M.D., Livingston; F. Mansel Dunn, M.D., Ingham; J. Bates Henderson, M.D., Huron; T. Y. Ho, M.D., Clinton; W. O. Jennings, M.D., Kalamazoo; W. S. Jones, M.D., Menominee; G. J. Kemme, M.D., Ottawa; Felix J. Kemp, M.D., Oakland; John J. McCann, M.D., Ionia-Montcalm; R. Bruce Macduff, M.D., Genesee; John A. MacNeal, M.D., Hillsdale; J. E. Mahan, M.D., Allegan; A. P. Murphy, M.D., Saginaw; E. S. Parmenter, M.D., Alpena; Charles Paukstis, M.D., Mason; H. W. Porter, M.D., Jackson; G. B. Saltonstall, M.D., Northern Michigan; Charles R. Smith, M.D., Houghton-Baraga-Keweenaw; R. W. Spalding, M.D., Van Buren; Stanley A. Stealy, M.D., North Central Counties; Gordon C. Tornberg,

M.D., Wexford-Missaukee; R. L. Waggoner, M.D., Gratiot-Isabella-Clare; Arch Walls, M.D., Wayne. Executive Secretaries Else Kolhede, Wayne; and Sara M. Burgess, Genesee.

Keymen representing County Medical Societies were: R. J. Armstrong, M.D., Kalamazoo; J. C. S. Battley, M.D., St. Clair; M. G. Becker, M.D., Ionia-Montcalm; R. G. Cook, M.D., Kalamazoo; D. C. Eisele, M.D., Gogebic; Harold T. Groos, M.D.; Delta-Schoolcraft; Wm. M. LeFevre, M.D., Muskegon; F. E. Lutton, M.D., Clinton; G. F. Moore, M.D., Macomb; D. J. O'Brien, M.D., Lapeer; H. T. Sethney, M.D., Menominee; W. J. Smith, M.D., Wexford-Missaukee; R. E. Spinks, M.D., Luce; E. A. Thayer, M.D., Jackson; Gordon H. Yeo, M.D., Mecosta-Osceola-Lake.

Presidents of County Medical Societies who attended were: Warren E. Forsythe, M.D., Washtenaw; R. J. Fortner, M.D., St. Joseph; Albert Huestis, M.D., Monroe; L. W. Hull, M.D., Detroit; Leo E. Westcott, M.D., Kalamazoo; D. Bruce Wiley, M.D., Macomb; T. G. Wilson, M.D., Bay-Arenac-Gladwin-Iosco.

Representatives of the Woman's Auxiliary, totalling thirty-five, were present: Mrs. A. B. Aldrich, Houghton; Mrs. T. Grover Amos, Wayne; Mrs. W. H. Boughner, St. Clair; Mrs. R. S. Breakey, Ingham; Mrs. A. S. Brunk, Wayne; Mrs. A. L. Callery, St. Clair; Mrs. F. M. Dunn, Ingham; Mrs. C. G. Clippert, North Central; Mrs. Ward S. Ferguson, Kent; Mrs. R. J. Fortner, St. Joseph; Mrs. L. Gernald Foster, Bay; Mrs. H. L. French, Ingham; Mrs. L. W. Hull, Wayne; Mrs. W. H. Huron, Dickinson-Iron; Mrs. D. M. Kane, St. Joseph; Mrs. G. L. McClellan, Wayne; Mrs. R. Bruce Macduff, Genesee; Mrs. J. E. Mahan, Allegan; Mrs. F. B. Miner, Genesee; Mrs. R. S. Morrish, Genesee; Mrs. R. L. Novy, Wayne; Mrs. A. C. Pfeifer, Genesee; Mrs. Homes A. Ramsdell, Manistee; Mrs. H. D. Scarney, Wayne; Mrs. W. L. Sherman, Wayne; Mrs. E. F. Sladek, Grand Traverse-Leelanau-Benzie; Mrs. Paul S. Sloan, Houghton; Mrs. Franklin W. Smith, Newaygo; Mrs. L. Paul Sonda, Wayne; Mrs. O. D. Stryker, Newaygo; Mrs. Kenneth Stuart, Bay; Mrs. R. L. Waggoner, Gratiot-Isabella-Clare; Mrs. R. V. Walker, Wayne; Mrs. Merrill Wells, Kent; Mrs. D. R. Wright, Genesee.

MSMS Officers who attended included: President A. S. Brunk, M.D., Secretary L. Fernald Foster, M.D., Speaker P. L. Ledwidge, M.D., and Councilors W. E. Barstow, M.D., O. O. Beck, M.D., T. E. DeGurse, M.D., Fred Drummond, M.D., W. H. Huron, M.D., A. H. Miller, M.D., R. S. Morrish, M.D., E. F. Sladek, M.D., O. D. Stryker, M.D., and C. E. Umphrey, M.D.; and Past Presidents C. R. Keyport, M.D., Grayling; H. A. Luce, M.D., J. M. Robb, M.D., L. J. Hirschman, all of Detroit; P. R. Urmston, M.D., Bay City.

Editors present were: Wilfrid Haughey, M.D., *JOURNAL of the Michigan State Medical Society*; A. C. Pfeifer, M.D., *The Bulletin*, official publication of the Genesee County Medical Society.

Members of the MSMS Public Relations Committee who attended were: Fred R. Reed, M.D., Chairman; C. G. Clippert, M.D.; J. S. DeTar, M.D., and Homer A. Ramsdell, M.D.

Others who attended included: Professor Floyd E. Armstrong, Mt. Pleasant; Mrs. Paul D. Bagwell,

(Continued on Page 224)

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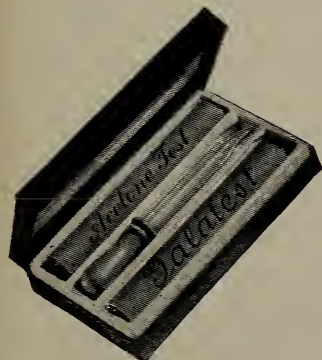
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COUNTY SECRETARIES CONFERENCE

(Continued from Page 222)

Lansing; Evelyn Barbour, Muskegon; J. J. Bauser, Detroit; W. H. Boughner, M.D., Algonac; A. A. Brindley, M.D., Toledo; R. W. Bunting, Ann Arbor; N. W. Burkman, Birmingham; Mildred Busch, Lansing; C. L. Candler, M.D., Detroit; J. W. Castellucci, Detroit; Charles Coghlan, Detroit; H. Earle Correvont, Lansing; F. Gordon Davis, Detroit; Carleton Dean, M.D., Lansing; Sidney Franklin, M.D., Flint; T. K. Gruber, M.D., Eloise; J. Joseph Herbert, LL.B., Manistique; H. B. Hogue, M.D., Ewen; J. W. Holloway, Jr. LL.B., Chicago; Henry S. Hosmer, Detroit; Chas S. Kennedy, M.D., Detroit; Jay C. Ketchum, Detroit; David Kliger, M.D., Detroit; Chester J. LeBoeuf, M.D., Saginaw; Harry R. Lipson, Detroit; K. E. Markuson, M.D., East Lansing; G. L. McClellan, M.D., Detroit; J. Earl McIntyre, M.D., Lansing; Harold A. Miller, M.D., Lansing; F. B. Miner, M.D., Flint; C. D. Moll, M.D., Detroit; J. G. Montgomery, Toledo; R. L. Novy, M.D., Detroit; Lt. Col. C. I. Owen, MC, Detroit; Katharine Post, Lansing; L. A. Potter, Lansing; G. H. Poulsen, Toledo; E. W. Schnoor, M.D., Grand Rapids; Leonard Schomberg, Petoskey; F. Maxwell Shuster, Detroit; C. E. Simpson, M.D., Detroit; Lillian R. Smith, M.D., Lansing; R. V. Walker, M.D., Detroit; Mrs. Grace Wallace, Onaway; A. V. Wenger, M.D., Grand Rapids; Howard R. Williams, M.D., Ann Arbor; G. H. Wood, M.D., Onaway; J. J. Woods, M.D., Ypsilanti; D. R. Wright, M.D., Flint.



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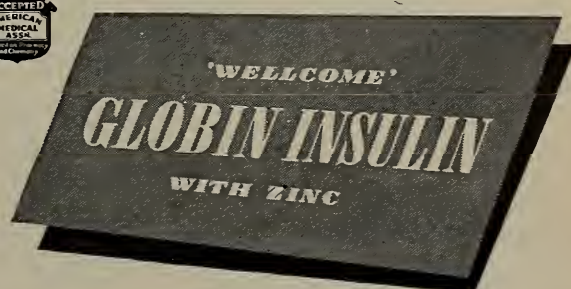


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'Wellcome' Globin Insulin with Zinc is intermediate in action between quick-acting short-lived regular insulin and slow-acting long-lived

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Michigan Medical Service

■ With repayment to the Michigan State Medical Society of its original contribution of \$17,544, Michigan Medical Service concluded 1944 as a year which seems destined to become memorable in the history of professionally sponsored medical service plans.

"In comparison," commented President R. L. Novy, "Michigan Medical Service had deficit in excess of \$500,000 little more than two years ago. This amount did not include the \$126,482 withheld during 1941 from payments to physicians or the \$17,544 contributed by the State Society. It seems clear that both public and professional confidence in the plan has been fully justified."



PRESIDENT NOVY PAYS PRESIDENT BRUNK

It was 1944 which demonstrated conclusively that professionally-sponsored plans are as practical financially as they are socially. The year also brought a notable gain in MMS enrollment, a new high in the number of services rendered to subscribers and payments made to physicians, and a popular vote confirming the public preference for physician-sponsored medical care plans over any other type of pre-payment.

Repayment of the \$17,544 contributed by the State Society was the final act clearing the Michigan Medical Service books of all old obligations. In addition, MMS also paid out during 1944 a total of \$126,482, which had been withheld from payments to physicians during 1941, completely wiped out a deficit which stood at \$186,242 at the beginning of the year, and finished the year "in the black" to the extent of \$194,016.

One of every seven persons throughout the state now is enrolled in Michigan Medical Service, the latest enrollment figures show. During 1944 alone total enrollment rose from 571,000 to 717,000.

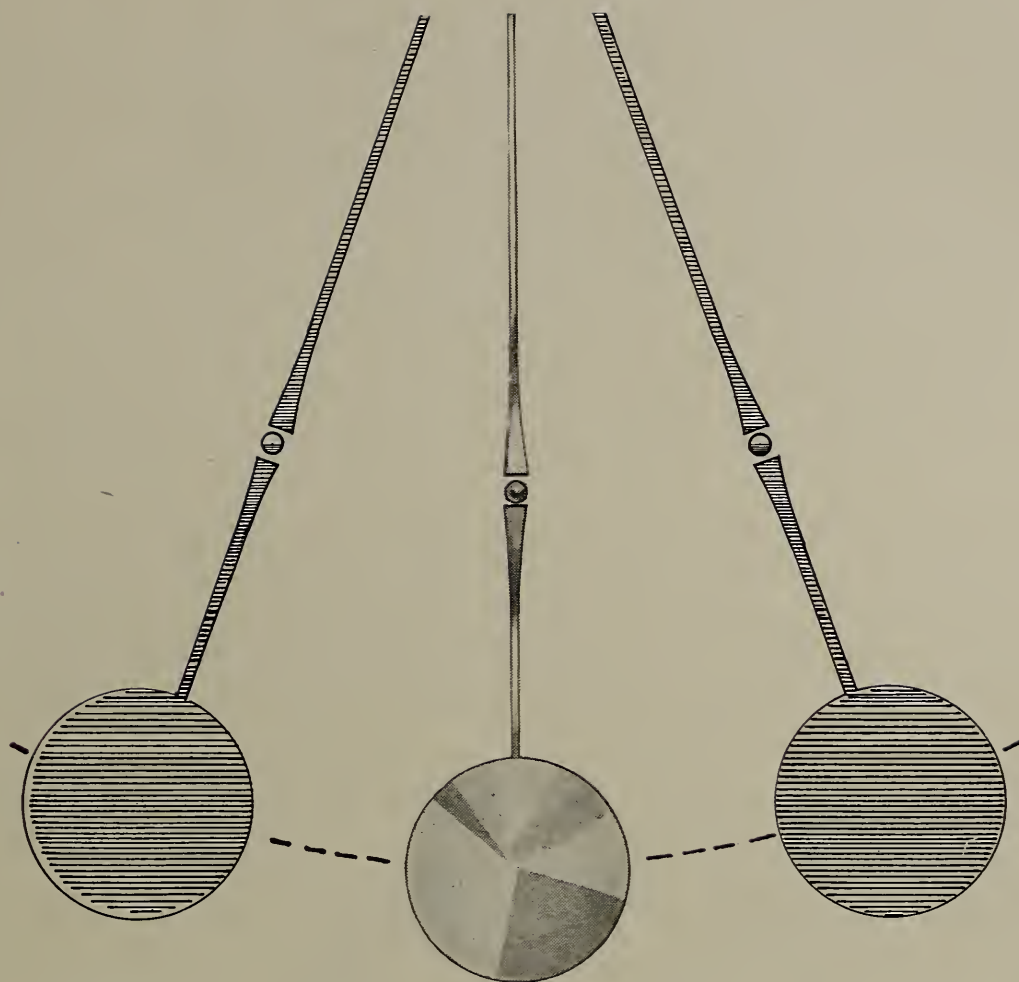
The year also saw services rendered to MMS subscribers in 63,888 cases, with payments going to doctors amounting to \$3,437,265.

"The fact that the public is thoroughly behind Michigan's medical profession in its endeavor to provide pre-paid services was further demonstrated in the survey conducted during 1944 by the Michigan Health Council," Dr. Novy said.


"The number of people choosing professionally-sponsored medical-hospital care was more than twice the number choosing any other form of prepayment.

"We feel that 1944 was a historic year in many re-

(Continued on Page 228)



Things you can count on.

THE  ALTINE COMPANY

**Esteemed by three generations of
physicians for dependable service based
on progressive, *productive* research.**

Established 1875, New York

MICHIGAN MEDICAL SERVICE

MICHIGAN MEDICAL SERVICE • WASHINGTON BLVD. BUILDING DETROIT, MICHIGAN •		No. 109670 DATE January 24, 1945
PAY <u>One Hundred Thousand and no/100</u> ----- DOLLARS \$ <u>100,000.00</u>		
TO THE ORDER OF [Michigan Hospital Service		
MICHIGAN MEDICAL SERVICE • WASHINGTON BLVD. BUILDING DETROIT, MICHIGAN •		No. 109671 DATE January 24, 1945
PAY <u>Seventeen Thousand Five Hundred Forty-Four and 45/100</u> DOLLARS \$ <u>17,544.45</u>		
TO THE ORDER OF [Michigan State Medical Society] MICHIGAN MEDICAL SERVICE		
L TO COMMONWEALTH BANK 9-31 DETROIT, MICH. 9-31		C12-646

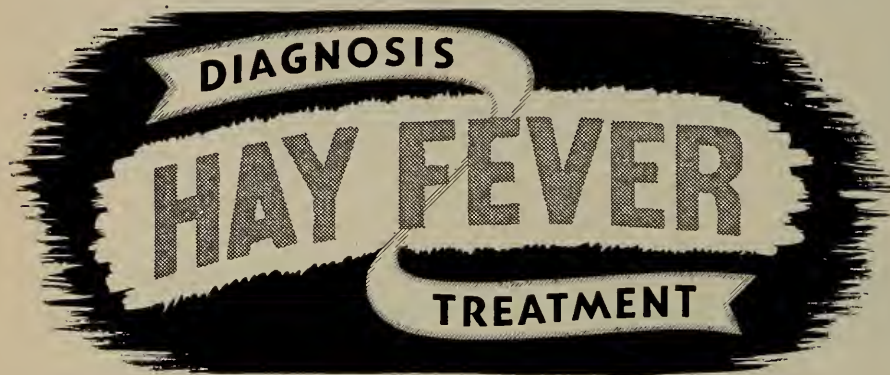
PROOF OF PAYMENT

spects. It brought convincing proof that the doctors' own medical care program serves an important social purpose, is wholly practical in the business sense and has the strong backing of the public.

"With the united support of the medical profession, only two major objectives remain to be achieved. We must progress with the utmost speed toward our ultimate maximum of enrollment, including farmers and

the self-employed, and we must broaden our protection to provide all the services the public desires as rapidly as sound planning permits.

"If we can achieve these objectives—particularly if we can do so in concert with other states—there no longer will be either the need or the demand for state control of medicine."



DIAGNOSIS: Individual diagnostic sets contain extracts of twelve pollens selected on basis of seasonal or geographic occurrence. Tests of all individual pollens are also available.

TREATMENT: All combinations of pollen extracts are available in either stock or prescription packages of three or four vials for pre-seasonal, co-seasonal and perennial treatment.

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Write for Literature



U. S. STANDARD PRODUCTS CO. Woodworth, Wisconsin... U. S. A.

3

ADVANTAGES OF

PRIVINE*

1. PROLONGED
VASOCONSTRICTION

Privine usually provides symptomatic relief from nasal congestion for 2 to 6 hours without reapplication.

2. SMALL DOSAGE

Only 2 to 3 drops of Privine are needed for prompt and prolonged vasoconstriction.

3. PHYSIOLOGICAL
RATIONALE

Privine is prepared in isotonic solutions strongly buffered to the same pH as the delicate nasal mucous membranes. It thus restores alkaline pathological secretions to normal acid range.

PRIVINE Hydrochloride

(NAPHAZOLINE)

DOSAGE: 0.1% for adults : 0.05% for adults and children.

*Trade Mark Reg. U. S. Pat. Off.

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IN CANADA—CIBA COMPANY LIMITED, MONTREAL

Political Medicine

PROPOSED AMENDMENT TO THE CONSTITUTION OF THE STATE OF MICHIGAN

The proposed amendment to the constitution of the State of Michigan's third revision would establish in this state a vast bureaucratic setup for the purpose of administering a fantastic compulsory "cradle to the grave" social security program for Michigan. The amendment proposes the establishment of a Social Insurance Commission which would be a law unto itself and all proceedings "shall be in accordance with rules prescribed by the Board of Review and need not conform with common law or statutory rules of evidence, or procedure and shall not be technical or formal."

The amendment would transfer the duties, powers, and functions of the following state agencies to the new commission: State Hospital Commission, Commissioner of Health, Tuberculosis Sanatorium Commission, Department of Health, State Accident Fund, Workmen's Compensation Commission, Appeal Board State Accident Fund, Employment Service Department Michigan Unemployment Compensation Commission, and Labor Mediation Board.

The newly created Social Insurance Commission would not only administer the duties of the old agencies but would add a multiplicity of new functions such as

(1) Health benefits—*Complete medical, surgical, obstetrical, dental, pharmaceutical, hospital, nursing, ambulatory, and laboratory* benefits. Diagnostic and curative procedures and treatment and periodic physical examinations would also be included.

(2) Disability benefits and maternity benefits.

(3) Unemployment benefits.

(4) And others.

It is proposed that this vast scheme be financed by a State Income Tax on individuals' incomes at the rate of

1 per cent on the first \$1,000.

2 per cent on more than \$1,000 but not exceeding \$3,000.

3 per cent on more than \$3,000.

Self-employed persons also pay these rates.

Employers shall pay (in addition to contributions paid into Unemployment Compensation Fund or payment of insurance premiums or contributions for workmen's compensation) 2 per cent of remuneration paid an employee.

All doctors of medicine including ophthalmologists, and all hospital administrators, dentists, optometrists, physio-therapists, pharmacists, nurses, should note that the *new amendment* would authorize one man (Commissioner of Health Insurance) to

(1) make regulations for health and medical practice;

(2) fix compensation;

(3) appoint assistants and local advisory councils;

(4) negotiate with representatives of employes and representatives of groups of persons with whom arrangements are made for professional services with respect to compensation and conditions of service;

(5) make grants in aid to universities for medical research and medical education;

(6) make studies and surveys of services furnished by practitioners and hospitals and of the quality and adequacy of such services.

All insurance companies and representatives of various types of insurance programs should note that the new Amendment does the following:

(1) Gives the State of Michigan a monopoly of all health, surgical and hospital insurance.

(2) Gives the State of Michigan a monopoly over insurance for Workman's Compensation.

This Amendment if passed will set up a State Agency that will regiment all *free* workmen and self-employed people in the State of Michigan. The free worker of today will pay for all benefits received by the addition of a State Income Tax to an already heavy tax burden. He will lose his freedom to choose the medical practitioner of his choice even though the Amendment purports otherwise. He will be forced to abide by all the rules, regulations and red tape which naturally ensues when he is compelled to deal with an agency of the government because such an agency must protect itself from public criticism. The health of the free citizens of Michigan will become a matter of public record! No health service purveyor may make any charge or claim for services upon any qualified individual for service benefits.

All professional groups—doctors of medicine, dentists, optometrists, nurses, pharmacists, hospital administrators—all who are even remotely dealing with the health of people will come under the control of the Commissioner of Health Insurance. Regimentation and Health Totalitarianism will have come to Michigan at a time when thousands upon thousands of Michigan's M.D.s, nurses, pharmacists, and others, are on the Fighting Front giving up their lives to crush the forces that take away man's freedom.

MULTI-BILLION-DOLLAR HEALTH PLAN IS URGED BY SENATE GROUP

Washington—(U.P.)—This country has been neglecting its health for years—witness the nearly 9,000,000 men of military age who are unfit for military service—and a senate subcommittee proposed today that something drastic be done about it as soon as possible.

It proposed a gigantic, multi-billion-dollar health and medical facilities program to be worked out now and

(Continued on Page 232)

U.S.P. ★ N.F.

WARREN-TEED Makes Medicaments of Exacting Quality



To fill your prescriptions, there is available a large number of Warren-Teed U. S. P. and N. F. preparations — medicaments of exacting quality.

Specify Warren-Teed U.S.P.

Tablets

Nicotinamide Tablets
Riboflavin Tablets
Sodium Salicylate Tablets
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Thyroid Tablets

Capsules

Pentobarbital Sodium Capsules
Totaquine Capsules

Elixirs

Elixir of Phenobarbital

Ointments

Ammoniated Mercury Ointment
Zinc Oxide Ointment

Tinctures

Camphorated Tincture of Opium

Specify Warren-Teed N.F.

Tablets

Ammonium Chloride Tablets
Calcium Lactate Tablets
Methenamine and Sodium Biphosphate Tablets
Potassium Permanganate Tablets
Three Bromides Tablets

Ointments

Ointment of Calamine
Ointment of Ichthammol

Miscellaneous

Camphorated Phenol Solution of Ephedrine Sulfate

Warren-Teed Ethical Pharmaceuticals: capsules, elixirs, ointments, sterilized solutions, syrups, tablets. Write for literature.

WARREN-TEED

Medicaments of Exacting Quality Since 1920

THE WARREN-TEED PRODUCTS COMPANY, COLUMBUS 8, OHIO



HEALTH PLAN*(Continued from Page 230)*

put into effect "as soon as materials and labor become available" in the reconversion period.

The program, involving close federal-state co-operation, would reach into every community in the nation and would make available to all citizens not only curative medical care, but also preventive and diagnostic services now lacking or inadequate in many sections and levels of society.

The proposals were offered in an interim report by the senate subcommittee on wartime health and education on the basis of findings assembled at hearings during the past year. The subcommittee, headed by Senator Claude Pepper (D., Fla.), heard scores of witnesses representing the U. S. public health service, the American Public Health Association, the American Medical Association, the Army and Navy, and the selective service system.

Recommendation No. 1 is for federal grants-in-aid to states now to assist in postwar construction of hospitals, medical centers, and health centers in accordance with state plans approved by the public health service.

This program for what the subcommittee called "a co-ordinated network of medical centers" in states and communities would involve initial expenditure of \$2,000,000,000 for construction and supplies, according to testimony by Surgeon General Thomas Parran.

The upkeep and implementation of other proposals by the committee would cost unestimated millions more.

The subcommittee cited as proof of the need for such a program the following data assembled during its investigations:

1. More than 23,000,000 Americans in 1935 had a chronic disease or a physical impairment.
2. Illness and disability cost the country more than 600,000,000 man-days a year.
3. From Pearl Harbor to Jan. 1, 1944, job accidents took the lives of 37,600 U. S. workers, 7,500 more than the military dead for the same period.
4. About 4,500,000 young Americans have been classified 4-F. In all, the subcommittee said, "it is estimated that at least 40 per cent of the 22,000,000 of military age—between 8,000,000 and 9,000,000—are unfit for general military duty."

Public health estimates, the subcommittee said, show that the nation needs facilities for 10,000 new general hospital beds, 94,000 new nervous and mental hospital beds, and 44,000 tuberculosis beds.

In addition to the proposed medical center networks, the subcommittee recommended:

1. Federal loans and grants for postwar provision of urban sewage and water facilities and rural sanitation programs.
2. Full-time local public health departments in all communities.
3. Expansion of Army induction program in order to rehabilitate men now rejected.
4. Federal grants to states to assure medical care for the needy.

**REPRESENTATIVE DINGELL REINTRODUCES
COMPULSORY SICKNESS INSURANCE BILL**

The 79th Congress convened January 3 and on that day Congressman Dingell, Michigan, reintroduced the Wagner-Murray-Dingell Bill as H.R. 395. It was referred to the House Committee on Ways and Means. The Senate version of the bill has not as yet been introduced, but the medical provisions of H.R. 395 are identical with those contained in the legislation that was before the 78th Congress.—*J.A.M.A.*, Jan. 13, 1945.

THE WRONG WEATHER MAP

A congressional committee which has been investigating the scores of hospitals already established to treat wounded soldiers has reported that for the most part the soldiers are getting the best of care. It did find some instances of maladministration, which are excusable in an rapidly expanding organization if they are corrected as quickly as they come to light.

One thing that the committee did uncover, however, should give every citizen pause when the proposal to federalize medicine and hospitalization for civilians is brought forward. A rather wide lack of air conditioning was discovered in hospitals where it should have been installed. Operating rooms were found so hot as to be unbearable and in orthopedic wards, the report says, the sufferings of patients in plaster casts were intensified during hot weather. The congressmen attribute the lack of air conditioning where it is needed to the army's system of deciding where it should be installed.

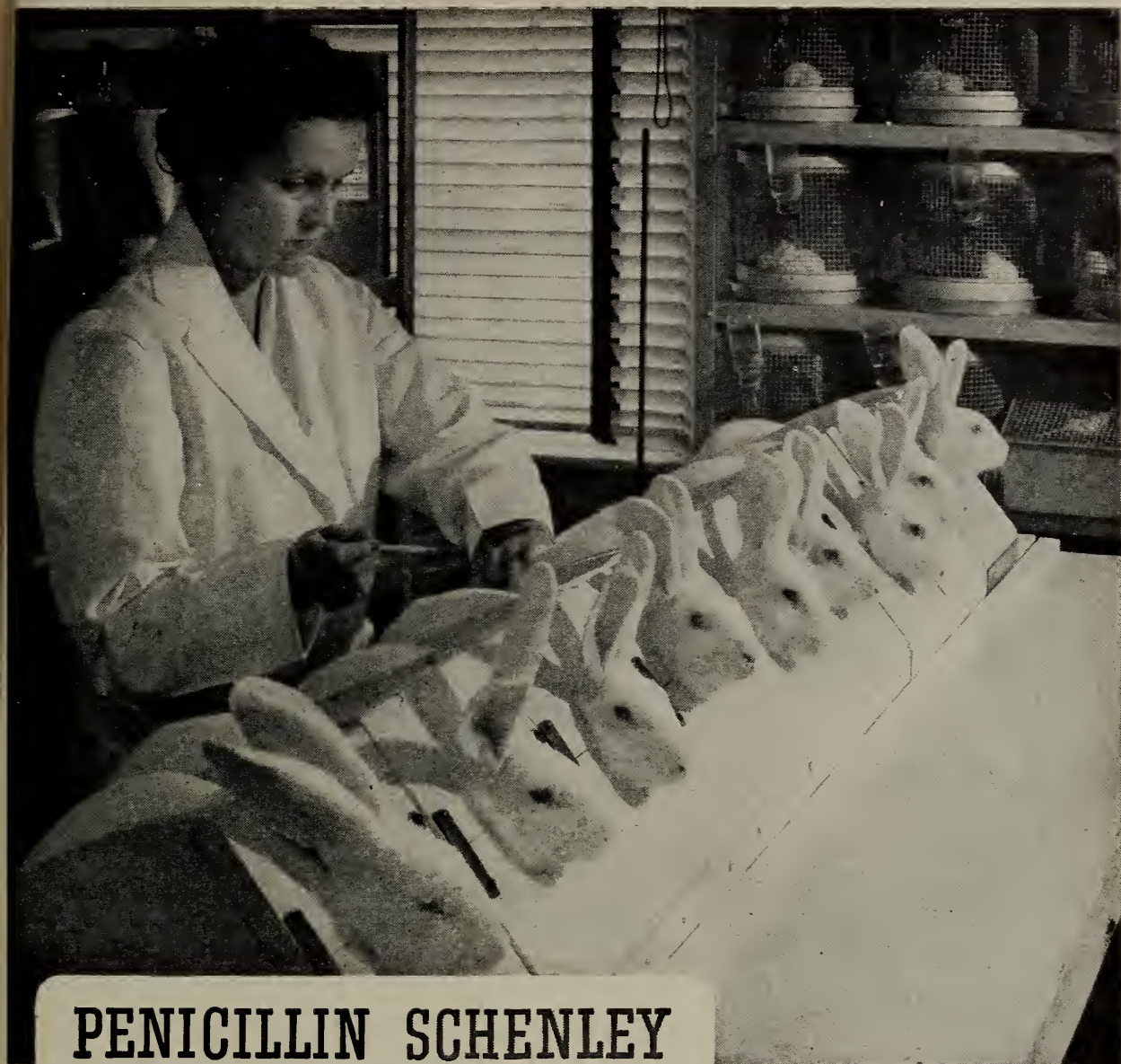
"It seems," the report said, "that for determining whether air conditioning is necessary the war department has theoretically divided the country into thermal zones which are based upon mean, high, and average low temperatures. Obviously, maximum temperatures and humidity, rather than average, should be the determining factor."

The army medical corps in time of war has the call on the best surgeons and hospital administrators in the country. Many physicians have left practices which yielded them handsome incomes to work for army pay. There is no lack of funds to equip hospitals and there should be no lack of equipment. And certainly the war department and the medical corps should be credited with the greatest good will in their effort to give wounded men the best treatment possible.

Yet under these circumstances men are found suffering unnecessarily. The reason lies in the inescapable stupidity of a bureaucracy. Staff it with the smartest people in the world and its red tape would still make their combined efforts stupid. Somebody in Washington decided that the proper way to allocate air conditioning equipment was to do it by a weather map. The wrong kind of weather map was picked, but nobody in the hierarchy seems to have had the initiative or the power to reverse the error made at the top, and so soldiers suffer.

No conceivable federalized health or hospital service could expect to draw to itself even a small measure of

(Continued on Page 311)



PENICILLIN SCHENLEY

Product of a common mold...but most uncommon care

The mold which produces penicillin is a mold of a fairly *common* variety, occurring freely in nature. But the production of penicillin for the medical profession depends upon precautions to insure sterility which are *most uncommon*.

One of the most important requirements of the finished penicillin is freedom from pyrogens. Each manufactured lot of PENICILLIN Schenley is tested (as illustrated above) to insure utmost pyrogen-freedom. Such measures of uncommon care will continue to assure the greatest degree of productivity . . . the highest degree of pyrogen-freedom . . . for PENICILLIN Schenley.



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MARCH, 1945

Say you saw it in the Journal of the Michigan State Medical Society

233

War Medicine

FIVE MORE TROOP SHIPS TO BE CONVERTED TO HOSPITAL SHIPS

Five more troop ships are being stripped of their armament and converted into United States Army hospital ships in order to insure speedier return of America's combat wounded.

The addition of these new ambulance-type hospital ships will bring the number of hospital ships operated by the Army up to 29 with facilities for transporting more than 78,000 sick and wounded.

Conversion of the new ships, which, together, will be able to carry 5,355 patients, will be completed in about four months. They will be painted white with red crosses and green bands—which insures protection under the Geneva Treaty—and be ready for service by June or July.

The *Saturnia*, with a speed of 19 knots and gross tonnage of 24,470, will be the largest and fastest hospital ship afloat. A former Italian luxury liner, built at Trieste, Italy, in 1937, she is 630 feet long and will have a capacity of 1,300 litter and 388 ambulatory patients.

The other vessels slated for conversion are the former French liners *Columbie*, with a capacity of 608 litter and 172 ambulatory patients, and *Athos II*, which will carry 615 litter and 264 ambulatory cases; the former United States liner *Republic*, with a capacity of 900 litter and 300 ambulatory patients; and the *President Tyler*, with a capacity of 650 litter and 158 ambulatory patients.

Two other Army vessels now are under conversion as hospital ships. They are the *Ernestine Koranda*, named for an Army nurse, and *Louis A. Milne*, named for a former New York Port surgeon.

COLONEL AHNFELDT ON "WE THE PEOPLE" PROGRAM

Lieutenant Colonel A. L. Ahnfeldt, MC, Director of the Sanitation and Hygiene Division, Office of The Surgeon General and Executive Chairman of the Army Committee for Insect and Rodent Control, was interviewed on the "We the People" radio program about the insecticide DDT. It is used in two ways, he said: As a dusting powder which is effective against lice and other disease-bearing insects; and in the form of an oil spray for killing mosquitoes and flies. Of course DDT is not a cure-all, he said, but in the perpetual war between humans and disease, DDT is one of the most effective health weapons yet discovered by man.

VETERAN'S HEALTH SERVICE

Under the various veterans laws as now constituted NO VETERAN need ever go without adequate hospital and medical treatment if he has a discharge "other than dishonorable."

Those with injuries or disabilities due to service of course get care without question. Regardless of financial status, they will be given transportation to a hospital, if that is needed, or treatment outside of a hospital if that is indicated. This includes dental work, medicines—anything that is needed. This same service is available if the illness was aggravated by service but was not actually incurred in service.

Veterans with illnesses *not connected with service* are, like other citizens, expected to take care of their own health in the ordinary manner. However, if the veteran is not able to pay, he can arrange to get the service free. He just has to swear that he is unable to pay for the needed service.

And any veteran unable to earn a living because of physical condition and without means of support may be admitted to a Veterans' Home.

NEUROTIC REACTIONS IN PSYCHOPATHS

In discussion at the meeting of the Society for Research in Nervous and Mental Diseases in New York City, December 15, Lieutenant Colonel N. Q. Brill, MC, stated that "although in most instances organic disorders can be differentiated from functional disorders with a reasonable degree of promptness and certainty, a problem which offers no ready solution is the differentiation of malingering from true neurotic reactions."

In conclusion he listed four important points (1) malingering and hysteria, while opposite poles of the same sphere, are clinically characterized by a gradual transition from one to the other. (2) An individual's past performance is the best clue to the type of mental process that is involved in a given functional disorder. (3) While malingering may be associated with any type of abnormal mental state, it is often symptomatic of a psychopathic personality. (4) Careful distinction should be drawn between individuals with psychoneurosis and those who by reason of defects of personality and/or intelligence, resort to conscious production of symptoms to avoid their obligations to society.

HEAD-WOUND GAS MASK NOW IN PRODUCTION

A gas mask to protect head wound patients from war gas has been developed by the Chemical Warfare Service at the request of the Medical Department, and is now in production the War Department has announced.

The mask is the first such device especially designed to protect patients with bandaged heads, faces, or jaws. It consists of a silk-like plastic hood to which an air-purifying canister and an outlet valve are attached. A flexible window across the eyes provides clear vision. Air is drawn into the mask by the ordinary breathing of the wearer.

The mask is pulled over the head like a sack, and ex-

(Continued on Page 236)

WHEN MILK BECOMES "FORBIDDEN FOOD"



SYMPTOMS

Persistent G.I. disturbances
eczema allergic rhinitis

DIAGNOSIS

Infant shows obvious
allergy to cow's milk

TREATMENT

Replace with suitable hypoallergenic substitute
(Mull-Soy)
Eliminate milk from diet

COMPARATIVE COMPOSITION

1 Part Mull-Soy	Average Whole
1 Part Water	Cow's Milk
3.1% Protein	3.3%
4.0% Fat	3.8%
4.5% . . Carbohydrate . .	4.9%
1.0% . . Total Minerals . .	0.7%
87.2% Water . . .	87.3%

Each provides 20 calories per fluid ounce



R

MULL-SOY FOR EQUIVALENT NUTRITION

While the manifestations of milk allergy or intolerance are most often seen in infants, they may be present at any age. And, when successful treatment demands complete elimination of milk from the diet, replacement by food approximately equivalent in nutritional elements becomes imperative.

MULL-SOY is an effective hypoallergenic substitute for cow's milk... a concentrated, emulsified liquid soy bean food which closely approximates cow's milk in protein, fat, carbohydrate and mineral content. It is palatable, well tolerated, easy to digest, and easy to prepare. Infants particularly relish MULL-SOY... and thrive on it!

Copies of "TASTY RECIPES FOR MULL-SOY IN MILK-FREE DIETS" are available for distribution to milk-allergic patients. Write

BORDEN PRESCRIPTION PRODUCTS DIV., 350 MADISON AVE., NEW YORK

MULL-SOY

Hypoallergenic Soy Bean Food

MULL-SOY is a liquid emulsified food, prepared from water, soy bean flour, soy bean oil, dextrose, sucrose, calcium phosphate, calcium carbonate, salt and soy bean lecithin, homogenized and sterilized. Available in 15½ fl. oz. cans at all drug stores.



WAR MEDICINE

(Continued from Page 234)

periments at the Medical Research Laboratories have shown it to be comfortable to the wearer as well as efficient.

IMPROVED FOOD PACKAGE FOR INVALID PRISONERS OF WAR

The latest—and third—version of the food package being shipped to invalid American prisoners of war by the American Red Cross is designed not only to build health, but to boost morale. Tempting recipes by Miss Jane Spinella of the Army Medical School gives directions for such delicacies as eggnogs, custards, puddings and welsh rarebits and suggest how to vary the dishes through the addition of flavorings. Miss Spinella also advised on the make-up of the package which contains dried milk, dried eggs, edible starch, oat cereal, salt and pepper, chicken or roast beef, tuna fish, cheese, butter spread, biscuits, peach jam, sugar, coffee, chocolate, vanilla tablets, dates, cigarettes and multi-vitamin tablets. 100,000 of these new-type packages are now ready for shipment.

COLONEL MENNINGER DISCUSSES NEUROPSYCHIATRIC CASUALTIES

Speaking before the meeting of the Association for Research in Nervous and Mental Diseases, in New York City, Dec. 15, Colonel W. C. Menninger, MC, Chief Consultant in Neuropsychiatry, Office of the Surgeon General, discussed the problem of the discharged neuropsychiatric patient.

Declaring that the problem facing the individual and communities is unquestionably of great magnitude, Colonel Menninger said that "the statisticians' figures of the number of such men is prone to be interpreted as indicating a much more alarming state of affairs than actually exists."

Colonel Menninger pointed out that neuropsychiatric casualties of the last war were extremely expensive in manpower and money. He asked the co-operation of the association in debunking misconceptions about the neuropsychiatric and educating the public concerning the problems involved. "We should provide counsel and advice to our federal, state and community leaders in the development of a plan for this group," he said, and concluded with the words, "We as physicians, and particularly as psychiatrists, have probably the greatest responsibility in helping GI Joe with a neuropsychiatric diagnosis readjust to his civilian life, and his civilian community to adjust to him."

PROMOTION

Robert Collier Page, M.D., of Detroit, has been promoted to Lieutenant Colonel.

UNUSUAL BRAVERY OF THE MEDICAL CORPS

The heroic and self-sacrificing acts of many men of the medical corps have been repeatedly noted under Medicine and the War in THE JOURNAL. Feats of combat pilots, gunners, submarine crews, pioneer troops and tank crews are frequently vividly described in the news-

papers. Physicians with the armed services are daily performing great and small acts of heroism in the care of the sick and injured. Often their work is unnoticed beyond the small group in which they regularly do their professional duties. A War Department release of November 19 announces the award of the Silver Star to five men, of whom three were members of the Medical Corps of the Army of the United States. Among twenty-two men awarded the Bronze Star Medal, seven were medical officers and eight enlisted men of the Medical Department. Nearly all of the citations were given for the high devotion to duty displayed by medical officers in going to the aid of wounded soldiers in the face of intense enemy infantry and artillery fire with utter disregard for their own personal safety. This record all doctors may share with pride.—J.A.M.A.

POSTWAR ADVANTAGES FOR ARMY NURSES

In connection with the present drive for Army Nurses, attention is drawn to the great postwar advantages being gained by Army nurses—priceless experience that will put them in the foremost ranks of their profession after the war.

In the words of Major General Norman T. Kirk, The Surgeon General, "The Army Nurse is living five years ahead of the nursing profession. She is handling new drugs, applying new treatments and working with the surgeons who are making history in medical circles during this war. She is gaining experience years ahead of her civilian opportunities." The urgent need for nurses continues to be critical . . . the Army Nurse Corps appeals to all qualified nurses to join NOW.

FIRST OVERSEAS CAPTAINCY FOR ARMY DIETITIAN

Cathryn Ver Murlein, of Grand Haven, Michigan, is the first Army Dietitian to be promoted to the rank of captain while on overseas duty, according to word just received by the Office of The Surgeon General. Captain Murlein was promoted from first lieutenant in recognition of her service while on duty at Headquarters, European Theater of Operations. She attended Battle Creek College and Michigan State University.

CIVILIAN CARE BY MEDICAL OFFICERS

May commissioned officers in the Army and Navy render professional attendance to civilians in this State?

The Michigan State Board of Registration in Medicine recently answered the above inquiry, as follows:

"The Medical Practice Laws of Michigan, Act 237, Public Acts of 1899, provide that commissioned medical officers of the United States Army, Navy, and Marine Hospital Service are exempt from registration and licensure to practice medicine in Michigan while in actual performance of their official duties to military personnel.

"Military medical officers may render first aid in emergency cases, after which the patients must be referred to legally registered and licensed doctors of medicine in Michigan for further necessary medical treatment.

"In professional attendance of civilians, the medical officer would not only violate the Medical Practice Laws of Michigan, but would subject himself to suits of malpractice from civilian patients."



Longer and busier work days, with a shortage of materials and skilled help—these and other worries that increase the tension of the war years play havoc with those health habits so essential to well-being.

...

Petrogalar gently, persistently, safely helps to establish "habit time" for bowel movement. An aqueous suspension of pure mineral oil each 100 cc. of which

contains 65 cc. pure mineral oil suspended in an aqueous jelly, Petrogalar is evenly disseminated throughout the bowel, effectively penetrating and softening hard, dry feces, resulting in comfortable elimination with no straining and no discomfort.

...

Five types of Petrogalar provide convenient variability for individual needs. Constant uniformity assures palatability and normal fecal consistency.

Petrogalar Laboratories, Inc., Division
WYETH INCORPORATED, PHILADELPHIA 3, PA.

Petrogalar
REG. U. S. PAT. OFF.

helps establish "Habit Time"



S U P P L I E D I N 8 A N D 1 6 - F L U I D O U N C E B O T T L E S

Progressive Michigan Medicine

MEDICAL PRODUCERS' CO-OPERATIVE

By STANLEY W. INSLEY, M.D.

Mr. President, fellow doctors and friends—We are not concerned tonight with waters already over the dam, nor with directing invectives against any union or committees, and certainly have no intention to eulogize any political Messiahs.

We shall confine ourselves to a situation and not to a theory or emotional opinion. This situation, as of today, is that the old American pattern of Medicine is past the proverbial crossroads. The distribution of medical care, as we and our fathers knew it, is apparently at the end of the road.

Tremendous economic and sociological pressures have become so all powerful as to force a changing pattern of human relationships all over the world, and naturally, upon our own country and customs.

There have developed, in this country, for example, the regulatory attempts against excessive corporate profits, new Exchange and Security regulations, Bank Deposit Insurance, the fostering of collective bargaining, the raising of wage levels and the insistence of at least a start on some sort of social security.

A not too curious concomitant of these social changes has been the evolution of class consciousness, with a remarkable growth and strengthening of workers' unions and of consumers' and producers' co-operatives.

Most individual laborers, farmers and professional men have very quickly appreciated the value of these unions and group co-operatives when dealing with outside interests, whether benevolent or hostile. It so happens, in our present complex economy, that a free society practically demands the existence of unions and co-operatives, else we may have either chaos on the one hand or dictatorship on the other.

Now, what as to medicine during these recent years of social changes? There has been a welter of criticism, some of it constructive and much of it unjustifiable. Most of the critiques are directed towards the lack of leadership shown from those in medical power who should have understood the doctor's problems, and yet be attuned to the times. Some of the accusations have had a rather ugly connotation.

All is *not* black on the medical front however, and I wish to point out a most remarkable fact; namely, that you and I here in Michigan have been developing the greatest "*medical co-operative*" of all times. It has been scarcely recognized as such except by a few.

I refer to "Michigan Medical Service," which is the medical example of a producers' co-operative; a picture of Michigan doctors forging ahead in a public health effort and through the channels of free enterprise. Mich-

igan Medical Service already offers medical catastrophe protection to more people than the combined efforts of all such organizations in the rest of America, and its potentialities for the public good are only now appreciated.

Michigan Medical Service has pioneered in its financial and organizational work and has come out of its early developmental stage as a sound financial and social structure. It can today offer an unparalleled service to corporations, the public or the government, with no less of freedom or initiative upon the part of its individual doctor members. This freedom and "wanting to do better" is in contrast to the usual high overhead costs and stultifying effects of the average governmental bureau.

I wish to next point out that it makes very little difference to a producers' co-operative whether it accepts equitable payments from a private corporation, a governmental unit or from some other consumers group. Multiple precedents have been established and it is simply an instance of one group being able to deal effectively with another group. An individual member of the producers' co-operative continues to act as a man of enterprise and free will, with adequate protection against capricious corporate or governmental rulings.

It should be emphasized again and again, that working men of free will and initiative, protected from inequities, can do *more for the public they serve* than if laboring under industrial brow-beating or political red tape.

There is one last point; the effectiveness of any union, co-operative or association is based upon the nearly total enrollment of its potential members into actual memberships.

I will, therefore, take the liberty of making a personal energetic plea to the effect that more and more of us become participating members in Michigan Medical Service—the "*doctors' co-operative*."

Certain impending legislation and its accompanying pressures make it clear that we as individual doctors are threatened, and are beyond the period of "Do nothingism."

We shall, from here on, have to act and live in co-operation, or be split by our enemies and destroyed by our quislings.

Address presented at a special meeting of the Wayne County Medical Society, December 5, 1944.

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Middle age to most men means the peak of their business and social careers. To meet these responsibilities, it should also mean the peak of their physical and mental efficiency.

Easy fatigability, exhaustion, insomnia, increasing indecision and irritability, as well as vasomotor, cardio-vascular, and genito-urinary disorders are often symptoms of endocrine imbalance during the male climacteric.

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Our Editorial Friends

ELECTION RETURNS AND THE DOCTORS

Uppermost in the minds of physicians is the question, "What significance does the recent national election have for the medical profession?" Those who have observed the Washington scene at first hand will have a ready answer. Legislation providing for the establishment of a national health program will undoubtedly be introduced. As regards the kind of a program which will be acceptable to Congress, much will depend upon what organized medicine does in the next few months.

The present Administration, as every physician knows, has been none too sympathetic to the viewpoint of organized medicine. Now that the Democratic majority in Congress has been materially increased, Administration leaders are undoubtedly of the belief that the people have given them the "go" signal on social legislation.

Of course, it is true that even among Democratic legislators there are many who oppose anything that smacks of "socialization" of medicine. This has been demonstrated time and again when medicine has come under discussion. These Democrats are just as adamant as Republicans where regimentation of medicine is concerned. But it is well to keep in mind that there is a growing sentiment favorable to broadening of the Social Security Act. There is also evidence to support the view that not only our veterans but all of our citizens will demand greater security in the postwar years.

This situation serves to confirm the opinion that your Observer has been on the defensive for too long. The American Medical Association should come forward immediately with its conception of a national health program. This program should include voluntary sickness insurance and diagnostic centers. It isn't enough to talk about the desirability of experimentation, to adopt platforms and principles. Our national organization must offer something tangible. Such a step will, to put it mildly, be welcomed by the rank and file of the medical profession, a great number of whom feel that it is long overdue.

Time is fast running out. We still have the ball. What are we going to do with it?—*Medical Annals*, December, 1944.

NOW IS THE TIME

Now is the time for all good doctors to tighten up professionally. A great many people are telling us how to do our job—the labor leader, the insurance man, the politician, the cracked pot reformer and many well-meaning hospital officials. But the bond between the patient and physician is still very well defined and will not change regardless of war and all its evils. Obviously most of us are very busy without the aid of business-getting tactics. Let us hope we continue to do without such methods.—Q. B. CORAY, M.D., Editorial *Rocky Mountain Medical Journal*, October, 1944.

SNOW

One of nature's marvels is snow. It descends on us pure white in the form of beautiful crystals with a pat on the cheek softer than a lover's caress. Yet the warmth of your hand will dissolve it so that it becomes a little drop of water which soon absorbs the dirt and dust of its surroundings and loses all its beauty.

So it is with our dreams of Utopia which gives us a world of peace, justice, health and happiness. But the slightest warmth of reality immediately dissolves these dreams and they gather in the sordid facts that we call Life.—W. B. HARM, M.D., Editor *Detroit Medical News*, Dec. 18, 1944.

ORGANIZED MEDICINE AND THE GOVERNMENT

With due respect to Senator Pepper, we maintain that far from being a nation of weaklings, our health record is second to none in the world. There is room for argument, to be sure, on what constitutes sound National Health. We should like to dispel the apparent belief among some of our superpromoters that medical Utopia is just around the corner. Actually it is no closer than it is in economics, in education, or in statesmanship. We simply do not know enough about the secrets of nature to prevent congenital deformities or to immunize against rheumatic infections. Nor have we found a method whereby we could make all people seek timely medical care. And while we are on the subject of timely care we suggest in full innocence that Government too often interferes with the process by legalizing cult practice. All of these factors play a part in our National Health status.—Editorial, *Nebraska State Medical Journal*, January, 1945.

PEPPER COMMITTEE HEARINGS

If we do not have inferior medical practice after the war, it will not be the fault of some of the chief witnesses who took part in the hearings. Not content with having curtailed medical education at both ends, they have now decreed that no more medical students shall be deferred, but that our medical schools will have to select their students from women and physically unfit men. It may be said, without disrespect to either class, that the practice of medicine is a rather strenuous occupation. Rural practice especially calls for sound bodies as well as sound minds.—*North Carolina Medical Journal*, October, 1944.

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Peripheral Nerve Injuries

By Major Frank H. Mayfield, MC, AUS
Cincinnati, Ohio



*Chief of the Neurosurgical
Section, Percy Jones General
and Convalescent Hospital,
Battle Creek, Michigan.*

been obtained. Nevertheless, it is inevitable that some will return to civilian life with residual disability. It seems timely, therefore, to report on our work at Percy Jones Hospital in Battle Creek, and call your attention to current research in the problem of peripheral nerve injuries, and to attempt to clarify certain fundamental principles of diagnosis and treatment that seem to escape general recognition.

Material

Between April 1, 1943 and August 1, 1944, a total of 391 enlisted men with peripheral nerve injuries were admitted to the Neurosurgical section of Percy Jones General Hospital. This does not include officer patients, or a large group with severe injuries to the skeletal structures. With few exceptions, the injuries were due to enemy action.

The incidence of involvement of various nerves is interesting, if not significant. The upper extremity was involved in 238 cases, the lower extremity in 149. The latter figure is relatively high as compared to the last war, and is evidently the result of change from trench to open warfare.

The ulnar nerve was involved in seventy-seven cases, the radial in sixty, the median in thirty-eight, and the brachial plexus in thirty-seven. Combined injury of the median and ulnar occurred in sixteen cases. The musculocutaneous was involved in two. The sciatic was involved in seventy-three instances, the peroneal in fifty-one, the tibial in only eighteen. The femoral was rarely involved, numbering only five cases. The lumbosacral plexus was involved in two instances. The facial nerve was involved four times.

Of the 391 cases, 133 patients have been operated upon. In fifty-nine instances, end-to-end

■ Approximately 10 per cent of war wounds involve major nerve trunks. These casualties require protracted and expert care, yet few recover completely. They constitute the greatest neurosurgical problem of the war. Peacetime injuries, for the most part, differ only in frequency and extent of tissue damage.

During the last war, repair of nerves was often delayed many months because of infection, or because the surgeon awaited spontaneous recovery. Shortly following repair in most instances the soldier was discharged. It was inevitable, that many would remain disabled by failure of suture or by stiff joints and muscle atrophy.

To avoid this in the present conflict, the Surgeon General of the Army has established Neurosurgical Centers in certain strategically located General Hospitals, with staff and equipment to provide adequate and expert care. Furthermore, it is required by directive that individuals be kept under observation until maximum recovery has

Read before the General Assembly of the Michigan State Medical Society, Grand Rapids, Michigan, September 28, 1944.

suture was done, and in seventy-four neurolysis was done. There has been a high incidence of painful paresthesias with lesions of the ulnar,

nerve showed return of voluntary motion four months after suture. The fibers had traversed a distance of 16 inches. Other sciatic injuries have required as long as sixteen months before any voluntary function returned.

The process of degeneration and regeneration of nerves is well understood. When a nerve is divided, the axis cylinders distal to the injury degenerate; whereas the encasing sheath of each fiber remains. The axis cylinders of the central end continue to grow with a considerable propelling force, and if the ends are in approximation they will grow down the remaining sheaths and function will return. While the generating force of the neural axis promotes recovery, scar tissue prevents it. Therefore, efforts of the surgeon are directed toward the restoration of continuity with a technique that minimizes scar tissue. Moreover, the nerve fibers must reach their end organ within a reasonable period of time or these organs will atrophy hopelessly.

The management of peripheral nerve injuries may be discussed under three general headings: Diagnosis, Operative Treatment, and Reconditioning. In application, however, these phases are not separable.

Diagnosis

The importance of diagnosis cannot be overstressed. Accurate diagnosis requires exact knowledge of regional anatomy and of the pathologic physiology of nerves, and willingness to carry out thorough and repeated examinations. It is essential that examination be done in a quiet, warm place, with the patient rested. Sensory and motor responses vary greatly when these conditions are not met.

Important information is obtained from the history. Paralysis following an incised wound is without exception due to a severed nerve. High-speed projectiles may cause paralysis by severance, or from contusion of a nerve, and only the course of developments will enable one to decide whether or not surgery is indicated. I would add, however, that where there is doubt, exploration should always be resorted to. Paralysis due to pressure or stretching is rarely amenable to surgery.

Recovery of function is difficult to appraise. Benisty¹ gives the order in which signs of regeneration appear as: (1) pain on pinching of the skin or pressure of the nerve below the lesion;

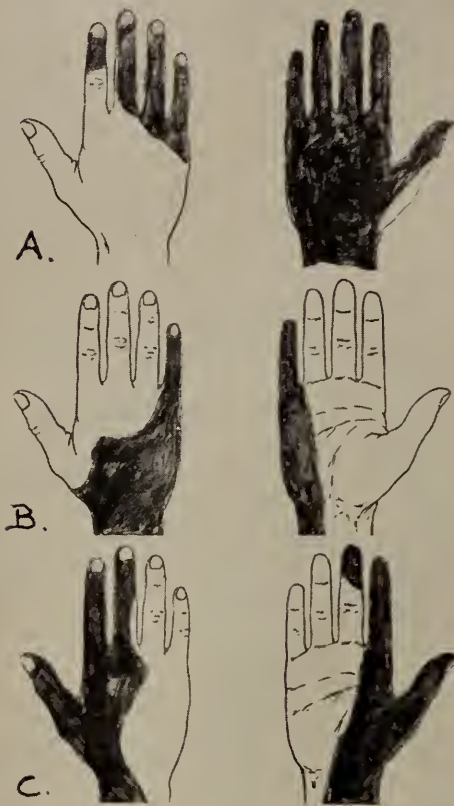


Fig. 1. Residual areas of sensation following multiple nerve lesions of arm. Shaded areas represent sensory loss to pin prick, and nonshaded areas, residual areas of sensation.

- A. After median and ulnar lesions (radial area).
- B. After radial and ulnar lesions (median area).
- C. After radial and median lesions (ulnar area).

median, and tibial. Neurolysis has been done in these cases, but results have not been satisfactory.

There have been twelve cases of severe causalgia in this group, eight of these patients were treated by sympathectomy, with complete relief. One patient having causalgia was relieved by fever therapy, and three have recovered spontaneously. In each case of causalgia the sciatic or median nerve was involved, and the lesion was incomplete.

Degeneration and Regeneration

Rates of regeneration vary tremendously with different individuals and with various nerves. One case with complete division of the sciatic

(2) the arrest of muscle atrophy and return of tone; (3) altered electrical response; (4) return of voluntary motion. Tinel's sign is designed to

eration. Immediately after division of a nerve, its skin area will show complete anesthesia (Fig. 1). Within two to three weeks, even though the



Fig. 2. Typical deformities resulting from paralysis of nerves.

- | | |
|--------------------------------|-------------------------------------|
| A. Wrist Drop (radial) | B. Claw Hand (ulnar) |
| C. Ape Hand (median and ulnar) | D. Winged Scapula (brachial plexus) |

aid in determining recovery. If regeneration is commencing, tapping over the nerve trunk below the lesion causes distal tingling. The tingling is produced by tapping on the growing end. By marking this place at regular intervals, the rate of regeneration can be determined. We regard it as a useful sign.

The extensive overlap of sensation between adjacent nerves is often misinterpreted as regen-

nerve ends remain separated, pain perception will return in part, so that finally, perhaps, only a small area may be completely anesthetic. Light touch will be absent as long as the nerve is divided. The pain perception in the overlap area is never normal sensation, however. When one is in doubt as to overlap, it is well to re-examine the patient after injection of the uninvolved nerves with procaine.

The primary function of various muscles and correct methods of testing their function is well described in most texts. The characteristic deformity with lesion of certain nerves is well known (Fig. 2). The associated or substitutionary movements that certain muscles take over when the prime movers of a joint are paralyzed are not generally understood, however. It is not within the scope of this paper to discuss in detail the anatomy and function of all the muscles of the extremities, but I would mention a few examples in which substitution is marked. With the median and ulnar completely paralyzed, the abductor pollicis longus, supplied by the radial, can flex the wrist. With the musculocutaneous paralyzed, the brachioradialis, supplied by the radial, flexes the forearm. The muscles of the shoulder girdle can abduct the arm when the deltoid is paralyzed.

Electrical Skin Resistance

Time does not permit discussion of the electrical stimulation of muscles in diagnosis, but I would call attention to the significant work of Richter and Katz⁷ on electrical skin resistance. The sympathetic innervation of skin is almost identical with the sensory dermatome. Due to loss of sweat, the anesthetic area has high skin resistance and the area can be mapped out accurately with Richter's Dermometer. This gives a method of objective testing that is valuable in checking progress and in eliminating functional disorders.

Surgical Treatment

Surgeons have utilized many ingenious devices for nerve repair. These include wrapping the suture site in fat pads, fascial sheets, preserved membranes and segments of arteries and veins. Clinical and experimental work of the last war proved that these devices defeat their purpose. For they act as foreign bodies and promote, rather than prevent, scar tissue formation. At the close of the last war, end-to-end anastomosis with sutures of fine silk through the epineurium had been universally adopted as the treatment of choice. This concept was not challenged until the present war gave impetus to new investigation. The subject was not ignored during that interval, however, for the epochal work of Pollock and Davis⁶ and Stookey⁹ appeared in that period. These, however, did not deal with technique.

Since the onset of the present war, several new procedures have been recommended; each of which has met with success in the experimental animal, but whose usefulness remains to be proven in the human.

Young¹⁵ has reported remarkable success in animals with cockeral plasma used as glue; and satisfactory results in a few human cases. The clot has low tensile strength, and was therefore not applicable in many human cases where nerve tissue had been lost. Tarlov¹⁰ has modified this technique, using autologous plasma with a special cuff for application. We have utilized the latter procedure in four cases, and with results as satisfactory as with suture, but the procedure, in our hands, has proved extremely time-consuming.

In 1939 tantalum, a metallic element, was introduced into surgery by Carney.³ It induces less tissue reaction than any foreign material yet used. It may be drawn into wire, and is now used to suture nerves. Spurling⁸ has advocated the use of a tantalum foil cuff about the suture site, to prevent the ingrowth of scar tissue, and believes that results are improved thereby. We have not seen fit to adopt the routine use of this procedure.

Weiss¹¹ has recently advocated a revolutionary concept in the repair of nerves. On the basis of certain animal experiments, he recommends that the nerve be encased in a tantalum cuff, with a gap of from 2 to 5 mm. between the ends, and this gap filled with blood. His concept is based on the observation that the fibers go through straighter because there is no pressure on the ends, and the lake of blood acts as a supporting matrix. Experiments are now under way to check this work, and to carry it over to the human.

The usual method of repair in our hands is end-to-end anastomosis with interrupted sutures of fine tantalum wire or fine black silk through the epineurium (Fig. 3). The nerve is identified above and below, and dissection carried toward the point of injury. It is a cardinal principle that incisions be long enough to avoid undue angulation or stretching of the nerve. The nerve is handled with fine instruments, and only moist gauze or cotton used for sponging. It is imperative that the nerve be mobilized sufficiently to permit suture without tension. Compromise with this principle inevitably results in failure. A stay suture may be necessary to prevent separation of the ends at times. However, when possible, this should be avoided.

Because most nerves contain motor, sensory, and autonomic fibers, it is necessary that axial rotation be avoided lest sensory fibers reach motor

served, and the injury is recent, release from the scar (neurolysis) is done. If there is no demonstrable function, and no response to faradic

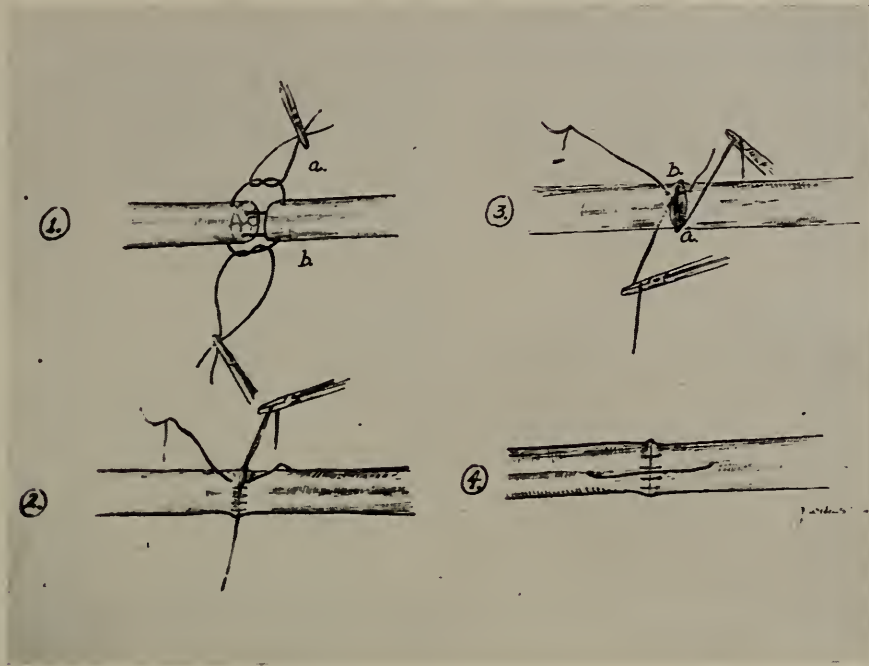


Fig. 3. Suturing technique in end-to-end nerve anastomosis.

end organs, or vice versa. This can be avoided by placing an identifying suture in the sheath above and below before lifting the nerve from its bed.

Both the proximal and distal ends of a divided nerve show neuroma formation. Foreign material is often imbedded within the neuromas and increases scar tissue production. This is excised back to healthy nerve fibrils; a sharp razor blade is used, and great care is exercised to insure that the ends are cut squarely. A common error among inexperienced surgeons is the suture of the proximal end of a nerve to the distal end of a tendon. While this seems inexcusable, it happens frequently.

When it has been necessary to flex the adjacent joints to accomplish suture, the extremity is encased in plaster for one month, after which all fixation is removed. Earlier partial mobilization has been abandoned as superfluous.

Partial Lesions

Partially divided nerves or ones showing neuromas in continuity present the greatest problem to surgical judgment. If some function is pre-

stimulation at the table, resection and suture is carried out.

Tendon Transplants

At times all efforts at restoration of nerve function fail. A very satisfactory functional result may be obtained by tendon transplantation in radial lesions, and reasonably satisfactory results in median and peroneal palsies.

Time of Suture

The work of Young¹⁴ demonstrates the value of early suture. Due to the advent of chemotherapy, it has usually been possible to effect operative repair quite early. Most of our cases have been repaired at intervals of one to two months after injury. Occasional ones have been delayed many months, due to associated infected compound fractures.

Military experience dictates that primary closure of war wounds must not be done, and patients may arrive in our hospitals with wounds that are granulating or recently healed. If there is no evidence of infection of the deep tissues, we give prophylactic sulfadiazine, excise the wound,

and close the skin. If no evidence of infection occurs within two weeks, repair of the nerve is then undertaken. Wound suppuration has been rare under this program.

At the present time early suture is being done on a group of cases in the European theatre. Close follow-up is being carried out on this group to determine, if possible, whether the advantage of immediate suture over a brief delay is sufficient to warrant the risk of intervention in recently contaminated wounds. Early impressions are extremely favorable.

The Closure of Wide Gaps in Nerves

At times it is difficult to effect adequate approximation when considerable nerve tissue has been lost. Gaps of one to four inches may be overcome in most of the nerves of the extremities by dissecting them out at considerable distance and then flexing the adjacent joint.

This writer has not found it necessary, in any instance, to resort to resection of the bones of an extremity to restore nerve continuity. Exception to this is made in the case of the brachial plexus, where it is advantageous to remove a segment of the clavicle for exposure. For a time, considerable effort was made in restoring the continuity of the clavicle. At the present time, however, a segment is removed subperiosteally, and left out. Regeneration of the clavicle, like a rib, takes place with surprising promptness.

It is common practice to stretch nerves where otherwise irreparable defects exist. This procedure consists of exposing the nerve, tying the two neuromas together with the adjacent joints flexed, then beginning gradual extension of the part until the joint is straight. Re-operation is then done and the neuromas excised, and the ends approximated with the joints again in flexion. Recovery following this is never good,⁵ but exceeds that of nerve grafts.

Nerve Grafts

It was generally concluded from the work of the first world war that grafts were valueless. This opinion is, for the most part, still generally accepted. However, it has been repeatedly possible in animals to get excellent return of function after the interposition of grafts. The work of Duel and Ballance⁴ in restoring the facial nerve, which is small, and that of Bunnell² on the digital nerves, indicated that grafts might be suc-

cessful. Almost without exception however, larger grafts have failed.

The supply of autogenous grafts is necessarily limited. Because of this, the use of homogenous grafts from the amputation stumps of other patients was begun. By combining at the same hospital an amputation center and a neurosurgical center, an adequate supply of nerves became available, and quite a few have been done. Woodhall¹³ has just completed a follow-up on fifteen homogenous grafts, and it may be said from this work that each was a complete failure, no fiber traversing the graft in any instance. Weiss and Taylor¹² began the use of frozen and dried cadaver grafts. By this procedure they felt that the incompatibility of tissues was removed, and that the nerve graft would then survive. Applying this to the animal, it worked satisfactorily. No human cases have been followed sufficiently long to test its efficacy.

It may be said in reference to grafts that small, autogenous grafts, such as the facial and digital nerves, may be used with reasonable expectancy of success, while an occasional instance of success is reported for larger grafts. Fresh homogenous grafts are valueless. The value of frozen, dried grafts remains to be determined. The difference in success between the small and large graft may be attributed to the fact that the small graft is bathed completely in tissue fluids from the time of its implantation; whereas the central portion of a larger graft dies before it attains a new blood supply.

Reconditioning

Rehabilitation must begin at the time of injury by preventing deformity and fixation of joints. Fractures of bones which require fixation in plaster, in association with nerve injury, are common. However, few require that the finger joints be encased, and this should be avoided. The patient should be instructed to use the unparalyzed hand for passive exercise of the paralyzed part. We have just completed the review of 100 cases of injury to one or more of the major nerve trunks of the hand. In 20 patients of this group, disabling stiffness of the finger joints existed. An analysis of their case histories made it clear that only one important principle of treatment had been violated; namely, they had not been instructed and required to passively exercise the paralyzed extremity.

Passive exercise to the foot is best applied by walking—all patients who can support themselves are fitted with appropriate splints and required to walk. We are convinced that passive exercise supersedes all other forms of physical therapy.

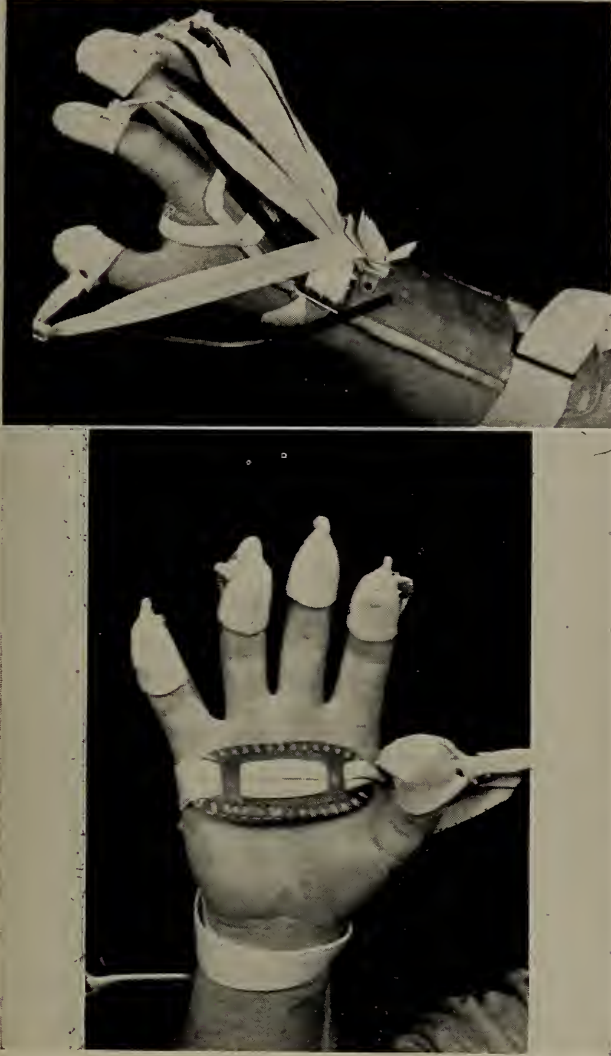


Fig. 4. Splint used to prevent deformity resulting from wrist drop (radial nerve lesions).

Splints

It is imperative that patients wear appropriate splints to prevent overstretching of paralyzed muscles, and contractures of unparalyzed muscles. An elastic cock-up splint which was developed at Percy Jones Hospital is used for radial palsy (Fig. 4). The wire drop-foot brace is used for peroneal paralysis. The airplane splint is worn by all cases with deltoid paralysis. There is no satisfactory splint for median and ulnar palsies. Full leg braces with knee drop locks are used for femoral palsies.

Physical Therapy

Heat and massage are given each patient daily. Massage must be mild, lest the paralyzed muscles and anesthetic limb be damaged. Every patient receives electrical stimulation of each paralyzed muscle daily. This limits atrophy and promotes improvement of circulation in the part by producing contractions of the denervated muscles. In addition to the treatment of the injured part, all patients engage in the general physical and educational program now in operation in all army hospitals.

Conclusion

In conclusion, the following principles and practices of nerve repair may be recommended: First, that physical therapy begin at the time of injury, to prevent deformity and fixation of joints; that the surgeon develop the technique of repair which minimizes scar tissue formation, and that the repair by end-to-end anastomosis with fine sutures of silk or tantalum through the epineurium be carried out at the earliest possible moment after injury.

It is recognized that present methods of repair are not satisfactory, and it is hoped that the clinical and experimental work stimulated by the great mass of material in this war will lead to more satisfactory methods.

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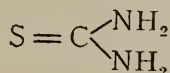
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Treatment of Thyrotoxicosis with Thiouracil

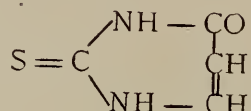
By William S. Reveno, M.D.
Detroit, Michigan

■ To the chance observation of the goiterogenic effect of the sulfonamides on the thyroids of rats, is to be credited the subsequent discovery of the thyroid inhibitors, thiourea and thiouracil.¹ The action of these agents, now under continuous investigation for the past two years, has been the subject of an ever-increasing number of reports, all of which attest to their positive therapeutic value. The instances of unfavorable and even serious reaction that have been encountered in approximately 10 per cent of the relatively small number of patients treated, have served to curb overenthusiasm, but have not interfered with the orderly progress tending to establish the true therapeutic value of these new chemicals.

Both thiourea and thiouracil have actions that are quite similar, but the effective daily dosage of the former is larger, being 1 to 2 grams daily, while that of the latter is .1 to 1 gram. The chemical formula of thiourea is



of thiouracil



Both are white crystalline powders. Thiourea is one-third as active as thiouracil, imparts a peculiar sweetish odor to the breath that is objectionable to patients, which is probably responsible for the more general use of thiouracil.

In action, these agents block or inhibit the formation of thyroxine in the acinar cell of the thyroid. They do not interfere with the action of preformed thyroxine, so that their inhibitory action does not become manifest until the latter has been completely used up or has undergone "decay." It appears reasonably established that the orderly interplay between the anterior pituitary through its thyrotropic hormone, and the thyroid, through thyroxine, is disturbed by thiouracil. Under normal conditions, a reciprocal relationship exists between the levels of thyroxine

and thyrotropic hormone. A fall in thyroxine is immediately followed by an increase in thyrotropic hormone with a resultant hyperplasia of acinar epithelium and increased production of thyroxine. As the level of thyroxine rises, the level of free thyrotropic hormone falls until balance is restored.

In hyperthyroidism, with the intrusion of thiouracil, and resultant interference with thyroxine production, thyrotropic hormone is elaborated in increasing amounts to produce hyperplasia and hyperemia, but without entirely fulfilling its mission. Hence, there arises an anomalous situation in which there is increasing hyperplasia and enlargement of the gland without production of new thyroxine. At the same time there is continuous loss through utilization of the thyroxine already formed. Thus the rate of metabolism falls and the disturbance resulting from excess thyroxine subsides. Obviously, this inhibitory action of thiouracil may be nullified either through removal of the pituitary, or through the administration of thyroid extract or thyroxine. Iodine not only has no effect, but actually delays the drop in metabolic rate. In fact, iodine appears to bypass the thyroid gland in the presence of thiouracil.

In a previous report² were submitted the results of treatment of nine thyrotoxic patients. Six of these showed excellent response, one was classed as a failure, and two discontinued treatment too early for evaluation. These patients had been observed over a period of nine months ending May 1, 1944. A total of twenty patients has now been treated, and the following report describes the observations that have been made.

To five of the original group, all with toxic adenomas, still under observation, have been added four with the same type of goiter, making a total of nine with toxic adenoma. Eleven patients with toxic diffuse goiter, four of whom have had thyroidectomy, are also under treatment. In the first group there are six females and three males ranging in age from forty to seventy-six. The second group consists of nine females and two males whose age ranges from sixteen to seventy-five. Two patients have been treated for sixteen months, two for fifteen months, one for fourteen months, one, eight months, one, seven months, five, six months, two, four months, four, three months, one, two months and one, one month.

Six of the patients with toxic adenoma and

From the Department of Medicine, Harper Hospital.

four with toxic diffuse goiter had been treated with iodine before starting thiouracil, one in the first group having been so treated for six years. Four patients had previously had thyroidectomy for toxic diffuse goiter. Two patients had auricular fibrillation at the beginning of treatment.

At the beginning of the study patients were started on .8 gm. thiouracil daily divided into four equal doses. Subsequently, this was reduced to .6 gm. daily divided into three equal doses. Reduction to .4 gm., then to .2 gm. daily was made as the BMR reached zero or a minus level. The amount of drug necessary to maintain the BMR between minus 10 per cent and plus 5 per cent averaged from .1 to .3 gm. daily. Patients were seen every two weeks before stabilization and every four weeks thereafter. Blood counts were made at each visit but blood cholesterol determinations were discarded since they proved of little value.

Clinical improvement occurred in two to three weeks in the patients with toxic diffuse goiter, previous treatment with iodine causing no delay. By contrast, it took approximately nine weeks before improvement appeared in those with toxic adenoma. Here the previous administration of iodine retarded the response quite noticeably. Weight gain and a feeling of well-being were the earliest signs.

Reduction of the basal metabolism to normal levels took place in from three to ten weeks in the toxic diffuse group and from two weeks to thirteen months in the toxic adenoma group. Again the retarding effect of previously administered iodine was manifest in those with toxic adenoma, the delay in reaching a normal metabolism being greatest in those under prolonged iodine treatment. Patients in whom iodine was discontinued showed a rise in basal metabolism during the first few weeks of thiouracil therapy but this promptly fell as the action of the thiouracil became effective.

Seven patients (all with toxic adenoma), have now been under treatment longer than six months. Only one of these has failed to respond in expected fashion, and after sixteen months' treatment is considered resistant to thiouracil. He is at present taking thiourea, but it is too early to report his response.

Thirteen patients (two with toxic adenoma, eleven with toxic diffuse goiters), have been under treatment six months or less. All are in a

state of remission. Nineteen of twenty patients have therefore responded favorably to the treatment.

Discontinuance of thiouracil in five patients in remission resulted in recurrence of symptoms in four. One of these, having had fourteen months' continuous treatment, remained in remission for three months without medication before relapse. A second patient maintained his quiescent state for only seven weeks following eleven months' continuous therapy. A third patient relapsed after seventeen days without thiouracil. The fourth patient, one with recurrent toxic diffuse goiter in remission after four months' treatment, relapsed three days after stopping thiouracil. The fifth patient, one with toxic adenoma, has continued in remission for four months, having previously been treated for a period of ten months. She is the only patient in the series receiving no medication. All the rest require from .1 to .4 gm. of the drug daily to remain in remission.

Goiters generally tended to increase in size and become softer during the early phase of treatment. This was more marked in the toxic diffuse group, and the subsequent reduction in size took place earlier in these patients than in those with toxic adenoma. Complete recession of thyroid enlargement did not occur in any of the patients under observation.

An unfavorable reaction was noted in only one patient, necessitating termination of treatment after thirty-eight weeks. A gastric upset occurred first on the eleventh day of treatment. This subsided on reduction in dosage, and the patient went on to remission at the end of the sixteenth week. During the thirty-sixth week, fourteen days after an attack of sore throat, she developed fever, malaise, and a generalized maculopapular eruption over the body. These symptoms subsided upon stopping the drug, but recurred one week later immediately following .1 gm. of thiouracil. Medication was discontinued and the patient has fortunately continued in remission for the past four months.

Three iodine-resistant patients, all with toxic diffuse goiter, are included in this series. One had had two series of x-ray treatments and was fibrillating at the beginning of treatment. The second patient had had two thyroidectomies with incomplete relief even though she had continued with iodine since her first operation. The third

patient had failed to respond to pre-operative iodine. The first patient was in remission, with regular cardiac rhythm established, nine weeks after starting thiouracil. The other two patients were controlled in four weeks' time.

Recurrent thyrotoxicosis was promptly relieved in three patients presenting this disturbance. One, a seventy-five-year-old man who had had thyroidectomy eighteen years previously, responded favorably after six weeks of treatment. The second and third patients were in remission at the end of four weeks.

Two patients with auricular fibrillation and decompensation, one with a toxic diffuse goiter, the other with a toxic adenoma, had normal sinus rhythm re-established after six weeks and eight weeks, respectively, of treatment with thiouracil.

An interesting observation of the effectiveness of thiouracil in the control of induced hyperthyroidism by overdosage with thyroid extract, is worth noting. Two male patients, aged forty-seven and thirty-eight, had a similar experience in that each was started on fairly large doses of thyroid extract on the basis of a single basal metabolism determination. The first, with a BMR of minus 30 per cent was ordered to take 6 grains of thyroid extract daily but this was reduced to 4 grains at the end of two weeks because of nervousness and nausea. He continued taking this amount for six weeks until he developed, in rapid succession, palpitation, sweating, weight loss, nervousness and insomnia. This continued in spite of his having had no thyroid extract for three months. Thiouracil .4 gm. daily for six weeks promptly put an end to the disturbance.

The second patient, with a reported BMR of minus 40 per cent, took an unknown amount of thyroid extract daily for six months when he developed tachycardia, nervousness and weight loss. Lugol's solution was substituted for the thyroid extract but the symptoms continued to progress. After four months, auricular fibrillation developed. The induced hyperthyroidism with fibrillation was controlled after six weeks of thiouracil therapy.

Summary

Nineteen of twenty patients with thyrotoxicosis responded favorably to treatment with thiouracil. Only one patient was resistant to the drug.

Patients with toxic diffuse goiter responded

somewhat more promptly than those with toxic adenoma. In the latter group, previous treatment with iodine delayed the response to thiouracil.

Only one patient developed an unfavorable reaction during the thirty-sixth week of treatment. This took the form of a generalized maculopapular rash, with fever and malaise. All symptoms disappeared on discontinuing the drug.

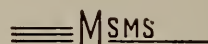
Three patients who were iodine-resistant, three with recurrent hyperthyroidism, and two with auricular fibrillation, responded promptly to treatment with thiouracil.

Two patients with hyperthyroidism induced by thyroid extract were readily relieved by thiouracil.

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TO HELL WITH THE DOCTORS?

Senator Claude Pepper, chairman of the Senate Subcommittee on Wartime Health and Education, in discussing the formulation of a national health program, says: "I've been trying to find a way of avoiding compulsion. I've been trying to find a co-operative method of solving our medical care problem."

This is a far cry from the belligerent, "to hell with the doctors" attitude that has motivated much of the controversy surrounding the issue of medical care. It indicates an awakening to the fact that the doctors are not opposing change solely through fear of how it might affect their pocketbooks. Undoubtedly many physicians would be better off financially under so-called medicine.

Their greatest interest, as they have been trying to make clear, is in maintaining high medical standards, the pursuit of independent research and the steady extension of medical service. They know from experience that these things cannot be attained unless medicine is preserved as a free institution; unless the doctors themselves are saved from becoming mere pawns in a compulsory, politically controlled medical system.

Sickness and hospital insurance with proper regulations we feel would be better than government bureaucracy controlled medicine.—*The Lapeer County Press and Lapeer Clarion*, December 23, 1944.

"AMERICAN MEDICINE"
The MSMS Radio Program

Station WJR
Every Friday, 7:15 to 7:30 p.m. EWT
Invite Your Patients to Tune In

Management of the Common Cold

By Arthur W. Proetz, M.D.
St. Louis, Missouri



Professor of Clinical Otolaryngology, Washington University School of Medicine; Editor of the "Annals of Otolaryngology and Laryngology."

The common cold is a combination of more or less constant symptoms attendant upon the sudden invasion of the upper—and sometimes the lower—respiratory tract. The distressing result, however, may be brought about by any of several causes. Until something specific is discovered which will either prevent or cure a cold, management must be largely dependent upon the etiological factors operating in the case in hand. Recovery depends upon the re-establishment of physiological conditions. Means will be discussed for bringing this about in given cases. Treatment will be discussed from the standpoints of prevention, amelioration of symptoms and shortening the course of the attack.

■ BEFORE setting out to lay plans for the management of the common cold, perhaps it would be profitable to decide just what is the nature of the thing that we propose to manage. Since both patients and doctors are apt to characterize almost any acute disturbance in the nose—or for that matter in the throat or the chest—as a cold, there may well be some divergent opinions as to what constitutes a cold cure.

Some fairly incredible cures have been reported to follow the use of some equally incredible measures. On reading the reports one often finds that the author has set up his own definition of a cold, which turns out to be some simple nasal congestion—a condition which can respond to anything which alters the vascular tone. For the purpose of this presentation a "cold" shall be regarded as an acute nasal infection (which may or may not involve the rest of the airways) characterized by obstruction, increased secretion, local pain or discomfort, some fever, and some systemic illness.

These symptoms appear in various intensities and proportions for the very good reason that

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they may be brought about by a variety of causes acting in dissimilar manners, and it is one of the first intentions to point out that, for this reason, there can be no general rules for the management of all colds. The practitioner's success with the individual case will be determined largely by his ability to recognize the factors operative in the given case. It may be added that while there are exceptions, it is the general rule that the colds experienced by some one patient result from the same causes, especially if they are of frequent occurrence.

The nose is exposed to all sorts of influences from within and without. From within, it is one of the most sensitive reactors to nervous, glandular, nutritional, toxic and other chemical disturbances in the body. The intricate network of vessels and nerves which constitute its erectile tissue makes this so. From without it is exposed to many kinds of atmosphere—fair and foul—in wide ranges of temperature, humidity and contamination. To these, with the advent of airplanes, we may add pressure. Unlike the conjunctiva, the nasal mucosa is not merely exposed to air, but it draws onto itself, in respiration, currents and swirls and eddies which intensify the irritating qualities of the air, deposit dusts and pollens, and produce dry spots.

Since almost any disturbance in nasal physiology can be the forerunner of a cold and since the upsetters of this physiology are many, it follows that we will do well to turn our attention away from the gaudy result which we recognize as a cold and direct it to the causative elements which are operative in the case in hand.

What are the agents which precipitate a cold? Immediately, bacteria. They are the chief cause of local discomfort, discharge and swelling, and are the result of other more important causes just a step to the rear. These are viruses; obstructive, vascular or allergic upsets; anatomical constrictions and deformities; and that thicket of biochemical entities roughly characterized as susceptibility, resistance and immunity.

One cannot indulge here in too long a consideration of nasal physiology, but if the measures later proposed are to rest upon a reasonable basis, it will be necessary to outline at least a few of the conditions which must be met before any degree of nasal health can be maintained.

1. The airways must be free and fairly equal but not necessarily symmetrical.

2. There should be no constrictions and if there are spurs and projections these will have to be so related to the passing air currents that they do not create eddies or jets.

3. For the proper heating and humidification of the air the nasal mucosa should function in its entirety. Portions of the nose should not be blocked and be out of service.

4. All portions of the nose must have ready, spontaneous drainage.

5. The membrane should be properly nourished.

6. The neurovascular control should be responsive but above all not oversensitive and overactive.

To my way of thinking, two things, without which no nose can be healthy, should never be lost sight of. First, the cilia should function throughout their normal distribution, which includes most of the nose and all of the sinus mucosa. Second, the mucous blanket should be present everywhere and should be of such thickness, tenacity and viscosity as to constitute an effective conveyor.

It is freely granted that adult noses—especially city noses—seldom meet these requirements fully, and that no special difficulty is experienced in many cases. As a rule, however, symptoms increase in direct proportion as these facilities break down, either in point of degree or in point of area. That is, a nose whose mucosa is everywhere subnormal or a nose in which there are patches of nonfunctioning epithelium is in for trouble. Of course much depends upon the location of such patches.

Theoretically, at least, no infection can take place so long as the mucous blanket is intact and moving. We are told that viruses can penetrate the blanket, paralyze the cilia and throw the whole mechanism, like the distracted centipede, into the ditch.

We know also that localized drying, produced by concentrated and ill-directed ventilation, causes local stasis and permits infection. What brings this about will be discussed presently under its proper heading.

With this lengthy but essential introduction we may face the patient with his cold.

As I see it, the first step is to determine if possible in which of several classes his cold belongs.

- (a) Is he a normal individual who has run afoul of a virus-induced epidemic?
- (b) Is his a body easily upset by accidents of temperature, excitement, mental stress,

diet, fatigue, nervous or glandular states?

- (c) Is his upper respiratory tract distorted in such a way as to produce localities of drying and irritation?
- (d) Is he the unknowing carrier of chronic sinus infection which may flare up under any of a dozen conditions to produce symptoms resembling an acute cold?

We will briefly discuss the management of each, frankly recognizing our limitations and making the best use we can of our present imperfect knowledge.

Epidemic Colds

There is evidence that viruses which may be said to "establish the beachhead" through which hordes of bacteria swarm to the attack, are themselves short-lived in an individual human body. They survive only so long as they continue to be transferred from host to host. However, the damage is done and the secondary invaders know no limitations.

It is my (unconfirmed) impression that viruses can be borne in upon a community infecting many people at a time. The number of patients attacked within a few hours seems to preclude any possibility of person-to-person dissemination.

We are all familiar with this situation. All at one time throats in great numbers become painful and people are uncomfortable out of proportion to the local mucosal reaction. Presently, when the discharge begins and the nose swells and the eyes smart, suffering is intense and the involvement violent and widespread, and there is every evidence of total infection.

The management of such a condition is largely dictated by the symptoms. I believe there is no known preventive. Isolation, if practicable, is indicated; usually in a civic community it cannot be effective. In army camps things are better controlled. But even here men may be loathe to report sick for any of a number of reasons until it is too late. It is known that persons in prime physical condition are no less susceptible to attacks than others. Previous attacks do not confer immunity.

What to do? Put the patient to bed and isolate him to prevent secondary infection as much as possible. Open his nose with the mildest *effective* constrictor. Avoid preparations, concentrations and methods of application which irritate. My

own choice is the medicine dropper. I avoid irrigations, as being useless in the obstructive stage and unnecessary later. The recuperating membrane trying to regain its normal tone and regenerate its surface layer of ciliated epithelium represents washing, squirting and any other form of insult. This is very patent to anyone who has observed these tissues under culture. For general treatment: aspirin gives some comfort. I know of nothing better. Resolution and freedom from complications depend largely upon the successful management of the secondary infection. The sulfonamides are indicated in proper dosage and for adequate periods; there still exists some difference of opinion regarding these.

The "Common Cold"

We turn now to Patient B—with a nose easily upset by environmental and bodily changes. He is the one who "takes cold easily" several times a winter. He is apt to have "summer colds." He is a city dweller, and constitutes the bulk of our office practice. We shall discuss him together with his neighbor, Patient C—one with a distorted airway—since the mechanics of the two conditions are closely related.

The symptoms displayed by these two individuals constitute what is usually meant by a common cold, yet even here there are etiological variations which call for modifications of treatment, although the symptoms may be alike.

Let us assume a normally functioning mucosa with ciliated epithelium and mucous blanket intact and examine the steps of a process which eventuate in a cold. The glands are so arranged and distributed and so nourished and stimulated as to maintain an even supply of mucus of proper physical properties—not too fluid and not too sticky—over the whole surface of nasal chamber and sinus. Anything which may produce even a local stasis long enough to permit bacterial penetration is a potential source of colds. Take the simplest example: Patient B goes to sleep in a cool draught. The resulting vasomotor upset causes the nasal mucosa to become congested until the airway, which is normally only a slit, becomes partly shut off. Inspired air passing through a reduced and now more or less tubular channel instead of being equally distributed is projected in a jet against some point in the posterior naris or the nasopharynx. Local drying occurs, the cilia cease to function, the mucus piles

up and becomes gummy. The patient is asleep and does not dislodge it. Stasis continues long enough for bacterial invasion and proliferation, the organisms enter the pharyngeal lymph channels and this is the beginning of a cold. Many patients recognize the burning in the nasopharynx as the precursor of a cold. If there are present no pathogenic organisms of any great virulence then there is only morning discomfort which clears up with some blowing, hawking, and swallowing. Otherwise a cold is soon in full swing.

Instead of sleeping in a draught any sudden chilling, fatigue, dietary indiscretion, alcohol, menstruation, or a metabolic or glandular upset can cause the same result. But since the cause is not the same, management cannot be the same. Successful preventive treatment depends upon intelligent recognition of the cause.

Treatment of the developed case in hand must accomplish two things: the removal of the cause and the artificial maintenance of conditions approximating the physiological until the nose can take over again, on its own.

The first and most important step is to get the patient's nose open—and *evenly* open—to re-establish even distribution of air. If one side of the nose is fairly free I let it alone and open only the blocked side. Overpatency of one side will aggravate the condition and we must seek to avoid this in our treatment.

I have no wish to hold out for any of the constrictors on the market. The solution used should be just strong enough to accomplish the necessary constriction. It should be as protracted as possible in its action and should have little systemic effect. (If systemic effect is desired I give ephedrine by mouth.) It should contain no irritating preservative—some of them do. I have seen irritations much worse than those of the infection result from their use.

I am not convinced that minor variations in the pH make much difference and have demonstrated experimentally, at least to my satisfaction, also that minor variations in the isotonicity are unimportant. pH and concentration are quickly altered in the nose. I do not mean that the druggist should be careless, but he need not carry his methods of precision beyond the ordinary routine.

Bed rest is advisable, in order to conserve his energies and protect him from temperature changes, if the patient will consent. Practically the only patients who will do it nowadays are

the workers who are allowed a certain number of days' absence for illness—on full pay. Failing this, I advise quiet and the avoidance of sudden changes of environment, especially heat and cold. Sitting and sleeping with the head high avoids obstruction somewhat.

A hot pack—up to the neck—within hours after the first chilly sensation, aborts many an attack. By dilating the splanchnic vessels it depletes the nasal vessels, and at the same time prevents the full-blown chill.

Etiological factors must be sought out and eliminated whenever possible. Diet should be adequate, balanced and simple.

The local drying in the nose, which has precipitated the cold, is compensated for by steam inhalations and by humidifying the living and especially sleeping quarters. Forty per cent humidity is normally desirable. Anything up to twice that is good treatment. Patients should have it explained to them that a pan of water on the radiator does not supply even a small fraction of the required moisture. Boiling or other forced vaporization is necessary.

Elimination should be active or induced to be so, but I do not give laxatives to patients whose habits are regular and continue so during the attack. The whole effort is toward normality everywhere; no violence.

There are almost as many cold medicines as there are doctors. My own choice is a half-and-half combination of aspirin and sodium benzoate—five grains of each every few hours is enough, and in fact is peculiarly effective. It makes the patient feel better, stimulates mild perspiration and I am convinced from personal observation but without further proof that it stimulates mucus secretion in the nose and pharynx, thus helping to overcome the dreaded dry spots which are in the process of forming.

I teach my patients to come in *at once*—not tomorrow—with the onset of symptoms. The situation is evaluated, the airway gently opened *and balanced*. Artificial humidification is begun. The patient is given drops and pills and a careful explanation of the mechanics of his trouble so that he may follow instructions intelligently.

If this is done at the engorgement stage and before bacterial penetration occurs—i.e. within the first few hours—the cold can usually be

aborted. Patients recognize this and co-operate fully.

If the cold is not aborted before the incipient stage is past it matters little what is done. I try to keep the nose and its meatuses clean with suction (thin cannulae applied to the secretion, never olive tips applied to the nostril) treat symptoms as they arise, and try to avoid complications. The events of this period often give the clue to the nasal defect which is the cause of the recurrent attacks: a constriction (mechanical or functional), a projection, an obstruction, a chronic hyperemia, a polyp, an atrophy, an underlying chronic sinusitis.

With this last we make the acquaintance of our fourth type, Patient D. Since this is not a lecture on chronic sinusitis we pass it by with the memorandum that chronic sinusitis may, either with or without an exacerbation, be the source of acute colds and should be treated with this in mind.

"Cold shots" I approve in principle—and mistrust in practice. They are experimentally logical and clinically disappointing. The mere fact that vaccines still hold a questionable place in our treatment after these many years of trial and the almost fatuous description of results obtained here and there, indicates that not much is to be expected of them. No such doubt clings, for long, to *bona fide* remedies: vide antitoxin, arsphenamine, penicillin and the sulfonamides. The uncontrolled evidence of John and Mary Doe that they are convinced that their colds are fewer and milder since they have been taking shots does not deserve the credulous attention it receives—partly because the variations in individual resistance with the seasons is well known, and partly because Harry and Jane Smith who had no relief whatever are less likely to be vocal about it.

The management of a little-understood disease requires more skill and application than that of something better understood. Treatment is less likely to be conventional. If we add to this that the common cold is in reality a variable group of symptoms arising from numerous causes, this becomes doubly so.

I have no apology to make for failing to advance a fool-proof, failure-proof method of exterminating our most destructive enemy, but cheerfully refer you to your Secretary, who assigned to me this controversial subject.

Use "M.D."

"There are doctors and doctors."

In the welter of the American system of conferring the title "Doctor" on all healers without distinction, and further as a reward for certain educational attainment, the people of this country have become confused by and indifferent to the title which not too long ago was a badge of special honor.

Members of the medical profession, the first group legally to merit the title "doctor," must take measures to distinguish themselves from others who bear the appellation. It has legal basis for insisting on use of the title "Doctor of Medicine" or its abbreviation "M.D.," since Michigan's Medical Practice Law specifically states that: "Any person who shall append the letters "M.D." or "M.B." or other letters in a medical sense, or shall prefix the title "doctor" or its abbreviations, or any sign or appellation in a medical sense, to his or her name, it shall be prima facie evidence of practicing medicine within the meaning of this act."

Only a Doctor of Medicine may use the abbreviation "M.D." Therefore, use it in preference to the unqualified and frequently ambiguous and sometimes illegally used title of "doctor." Use "M.D." after your name in the telephone directory, on your cards and stationery, and on your "shingle." The word "doctor"—and likewise the word "physician"—has been assumed, rightly or wrongly according to each individual case, by others. But only the Doctor of Medicine can use the letters "M.D."

Therefore, use "M.D." as a matter of public service. Aid the public in its search for the best in health care.



President, Michigan State Medical Society



President's



Page



ANNUAL MICHIGAN POSTGRADUATE PROGRAM FOR GRADUATES IN MEDICINE

The Michigan State Medical Society, in co-operation with the University of Michigan Medical School, Wayne University College of Medicine, the Michigan Department of Health, and the Wayne County Medical Society, announces the postgraduate courses for 1945:

INTRAMURAL COURSES

All Dates Inclusive

Anatomy.....	March 1-June 14 (Thursdays).	E. Med. Bldg., Ann Arbor
Internal Medicine		
Clinical Internal Medicine.....	March 1-May 3 (Thursdays).	University Hospital
Blood and Blood-forming Organs, Diseases of.....	May 14-18.	University Hospital
Gastroenterology	May 21-25.	University Hospital
Endocrinology and Metabolism.....	May 28-30.	University Hospital
Heart, Diseases of the.....	May 31-June 2.	University Hospital
Diagnosis, Common Problems in Differential.....	June 4-6.	University Hospital
Therapeutics, Recent Advances in.....	June 7-9.	University Hospital
Electrocardiographic Diagnosis	November 5-10.	University Hospital
Ophthalmology and Otolaryngology.....	April 19-25.	University Hospital
Pediatrics		
Newer Development in Medical Supervision of Children..	May 14-16.	University Hospital
Roentgenology, Diagnostic	April 16-20.	University Hospital
Summer Session Courses: Anatomy, Bacteriology and Biological Chemistry.....		
		July 2-August 24

EXTRAMURAL COURSES

Ann Arbor	April 12 and May 10
Bay City	March 28 and April 25
Flint	April 10 and 24
Grand Rapids	April 10 and May 8
Jackson	March 20 and April 17
Kalamazoo	April 17 and May 24
Mt. Clemens	April 11 and 25
Traverse City	April 11 and May 9

Subjects

The Differential Diagnosis in Peripheral Vascular Disease, including the Diabetic Foot and Its Surgical Management.
The Management of Sterility.
The Acute Diarrheas of Infancy and Childhood with especial reference to Epidemic Diarrhea.
Rheumatic Fever. Etiology. Diagnosis and Management.
Albuminuria. Laboratory Examinations of Value in Diagnosis and in Evaluating the Effects of Treatment.
The Intravertebral Disc. (Nucleus pulposus.)
Clinical Diagnosis. Indication for and Results of Nonoperative and Operative Treatment.

Upper Peninsula

The Upper Peninsula program will be given in
Houghton, Douglass House
Ironwood, St. James Hotel
Marquette, Northern Michigan Children's Clinic
Powers, Pinecrest Sanatorium
during the week of May 21-25. The detailed program will be mailed later to all physicians in the Upper Peninsula.

For further information, address H. H. Cummings, M.D., Chairman, Department of Postgraduate Medicine. University Hospital, Ann Arbor, Michigan.

Editorial

1945 DUES NOW PAYABLE

■ This is a reminder to all members who have not yet paid their 1945 dues. The County Secretary is as busy as you and has no time to send out individual statements. Such notices also use needed paper and postage. Your prompt check to the County Secretary will save time and expense as well as clerical effort. The dead line is March 31, 1945.

If each member whose dues and assessments are not yet paid will remit promptly, the work of the Society will go forward. It is not necessary to enumerate the advantages of paid-up membership, but it is a satisfaction to enjoy them.

Listen! WJR, Fridays, 7:15 p.m. EWT, MSMS Program!

POLITICAL MEDICINE

■ Let us stop talking about "Socialized Medicine!"

That subject immediately calls for a detailed definition such as the unduly quoted one by Leland* of the Medical Economics Bureau of the American Medical Association. The argument against "socialized medicine" has promptly lost half its zest in a definition that gets nowhere.

Let us dub the critter as it actually is: "Political Medicine." The appellation "socialized medicine" just befuddles the issue, misleads to involved and devious side issues, and confuses. If we insist on calling the rat by its proper name we may hope to have some success in nullifying its bite.

Why this thought now?

Two forces are working out a destiny for the practice of medicine in these free United States. The one is active, that of federal control, the brain-child of social dreamers, so-called "perfectionists," or do gooders, and has been at work long and arduously. The second force is that of

*"State Medicine" is hereby defined for the purpose of this resolution to be any form of medical treatment, provided, conducted, controlled or subsidized by the federal or any state government, or municipality, excepting such service as is provided by the Army, Navy or Public Health Service, and that which is necessary for the control of communicable disease, the treatment of mental disease, the treatment of the indigent sick, and such other services as may be approved by and administered under the direction of or by a local county medical society, and are not disapproved by the state medical society of which it is a component part.

Presumably, then, the socialization of medicine, as the term is commonly used, refers to any form of medical advice, diagnosis and treatment provided, conducted, controlled or subsidized by the federal or any state government with the exceptions stated.—R. G. LELAND.

inaction or misdirection on the part of so many of our medical leaders.

Our readers will remember that famous Committee on the Costs of Medical Care, which spent a million and a half dollars and five years' time, and brought forth a report exactly outlining what at its inception it was told it would or should find. Special articles appeared in papers and national magazines telling of the faults of medicine, its failures, and its shortcomings. This was also a season conspicuous for its dearth of articles defending the profession or even telling some of the favorable truths. When the stage was fully prepared came the indictment, the ranting up and down the country of the federal officers in charge of the grand jury "investigations," telling what was being *proved* in those hearings. And then the Court *Decision* by which the American people in effect lost their right to choose their own doctors.

In rapid succession followed the introduction of the Wagner-Murray-Dingell Bill, the encroachment on the practice of medicine by the Children's Bureau through its EMIC program, and the taking over and shortening of the education of doctors of medicine by the Military.†

The Messengers of Change are now starting to ride again. *Collier's* magazine for January 27, has an article by one of its staff hack editorial writers entitled "Do We Need a National Health Insurance?" which is flamboyant and completely unfair. It tells a story in a vein of assumed impartiality describing the utopian benefits which the Wagner-Murray-Dingell Bill will give to 110 million citizens of the United States. It mentions that there are many "small inadequate voluntary health plans," and it particularizes the California plan, but *it fails to mention the one outstandingly successful medical co-operative* which has convinced the citizenry of its state of its worth, and which is satisfactorily providing medical service to over 750,000 subscribers—Michigan Medical Service.

Collier's article does, however, stress that these plans have been opposed by the AMA, which it charges has been opposed to anything but the ancient fee for service, and solo practice. The

†See *Saturday Evening Post*, January 27, 1945, page 34.—Dr. E. A. Graham.

facts are inaccurate but are told in a manner to convince one of their truth. It does not tell, however, that the Wagner-Murray-Dingell Bill *makes no provision for the indigent.*

Collier's quotes and refers prominently to a group of "Doctors within the American Medical Association favoring the Wagner-Murray-Dingell Bill," thus by implication showing a lack of cohesive thinking by the profession. The group whom any self-respecting union man would label "scabs," are our old friends, some of whom voluntarily went to Washington to testify against the American Medical Association during the trial leading to the well-advertised Supreme Court Decision. In their prime they were recognized medical leaders but now would reflect credit upon themselves by withdrawing from the American Medical Association.

This article in *Collier's* has without a doubt been inspired as were so many in previous years. The author judging by her other articles has no special interest in, or knowledge of medicine. But the one reason for inspiring such articles is evident. The enemies of private medicine are again at their lethal tricks.

The people do not want Political Medicine, when properly labeled and *explained*. Doctor, it's your job and individual responsibility to do the talking!

Listen! WJR, Fridays, 7:15 p.m. EWT, MSMS Program!

WAGNER-MURRAY-DINGELL AGAIN

■ House Bill 395 of the 79th Congress has been introduced by Rep. Dingell and we may as well learn that number. It is the old Murray-Wagner-Dingell Bill, reintroduced January 3, 1945, and contains the same medical features with which we were so familiar. We will still have this monster to menace us, but with this unmistakable difference: The proponents of this "advanced" legislation have been returned to power with what they choose to consider a landslide vote, a mandate from the people to do their will with their favorite legislation.

We have all recognized a changing world, a revolution of ideas, a gradual turning toward "socialized" life and politics. But we had hoped the tide could be stemmed short of complete social revolution. Our political and bureaucratic leaders have interpreted the electoral votes as an expression of public opinion on medical matters vastly different from that shown by the sampling taken

in Michigan and published in November, 1944. We believe our test was more accurate, because the issue was plainly stated. The political issue was befuddled with personalities entirely masking the basic issues.

Since the new Congress has convened, one of our congressmen, who is opposed to the Wagner-Murray-Dingell Bill tells us that no amount of opposition, or argument, or of influence will change the trend that has set in. "The Wagner-Murray-Dingell Bill with modification is going through; it has been determined to socialize medicine, and that will be done."

Renewed efforts by the profession are imperative, and all of our doctors must help in the work, or the present structure of American Medicine will crumble. We have not yet become apathetic, but there is a handwriting beginning to show on the wall. Medicine **MUST** have a part in formulating the structure that is to emerge from the revolution now in process.

It is inconceivable that the people would voluntarily surrender the most effective health service in the world in exchange for a politically controlled pattern which would mean the immediate establishment of another bureaucracy of hundreds of thousands of political hangers-on looking for easy jobs, bossing the doctors around, telling them what patients they may treat, and what to use in treatment.

Listen! WJR, Fridays, 7:15 p.m. EWT, MSMS Program!

WE HAVE THE ANSWER

■ Michigan Medical Service has proved its capacity for service. Its financial stability is shown by its latest reports, and by the annual audit by the State Insurance Commissioner. We are now in position to offer to the people all the advantages the political medicine Wagner-Murray-Dingell Bill can give, and more satisfactorily. We have in force Surgical and Obstetrical services to almost one seventh of the population of the state, and have contracts ready for sale to include all medical (as well as surgical) services in the hospitals, at a nominal additional charge. These contracts may only be offered to groups, but those groups may be so comprehensive as to cover practically all persons needing the service. Groups of as low as ten are eligible, and those could be the people living in a city block, or any natural group.

We can also offer *complete* medical service in

the hospital, the doctor's office, the patient's home, when there is any demand for that service. This demand is not apparent in the recent survey conducted in Michigan. Persons on the known indigency lists, could be insured by the natural protectors of that group, the welfare agencies of the government, whose duty it is to care for them. Michigan Medical Service has the know-how, and the facilities to care for those groups. That goes a long step farther than the Murray-Wagner-Dingell Bill, and makes a potential availability of our service to every inhabitant of the state, those of higher income rating of course to be on an indemnity basis, as they are now.

Nothing in the plans of Michigan Medical Service or Michigan Hospital Service would prohibit an employer (or a Governmental agency) paying part or all of the premiums of subscribers. If government demands, the two services could administer and operate their services to the advantage of complete *population* groups, guaranteeing adequate medical and hospital care to all. Financing could be by payment of premiums to the services by whatever authority is interested in securing adequate medical and hospital care for its people.

Listen! WJR, Fridays, 7:15 p.m. EWT, MSMS Program!

OUR PROPOSAL

■ The medical profession has been accused of opposing progress—of objecting to measures to assure health services to all. Let us now replace objection with constructive plans. We have not changed our views on the objectionable features of this proposed legislation, the heir to the Wagner-Murray-Dingell Bill. Our objections throughout have been to regimentation, or bureaucratic control of professional services. The leaders of the medical profession have long been aware of a changing philosophy of furnishing medical care and have devoted many years of study to the subject—Michigan particularly spent over \$20,000 on such study nearly two decades ago.

We have been proposing and offering plans as fast as the public would accept, and actually were selling health services long before government became interested. We are still one step ahead. We are in position and ready to administer such services as are proposed by the Wagner-Murray-Dingell plan, but under certain conditions of professional supervision of the professional service. Government, if it insists, may collect the pre-

miums now done by employment through payroll deduction or *may establish a new income tax*. There is no fundamental difference, except the compulsory feature. One other group must eventually be included in our service plans—the individual. Present plans could be sold to individuals with only moderate changes. Much study has been given to the subject. When this group is included there will be no need for the compulsory scheme now being prepared for Michigan—the amendment to the Constitution.

Expansion of the Michigan plans can now be rapid, and must be, to meet the proposals of the apostles of "complete security for all." No bureaucratic plan can be as economical as our Michigan nonprofit plans, and that will be a convincing argument to the laborer who in the end is the one who pays the bill.

ROY C. PERKINS, M.D., RESIGNS

■ Roy C. Perkins, M.D., has resigned from the Council on account of health considerations. He has rendered yeoman service to the profession by his efficient conduct of his office and faithful execution of every task imposed upon him. His advice has been cool—directly to the point, and has been of immense value to the Council and the Society. His genial presence will be well remembered, and his return to active Society work is anticipated.

On the Council of the Michigan State Medical Society, Doctor Perkins served as Chairman of the Publication Committee, and as a member of the Executive Committee. He was also a member of the State Advisory Council of Health, and representative on the Rehabilitation Board of the State. Doctor Perkins honored the offices he held.

The Council accepted this resignation with regret, knowing that it would thus be deprived of his sage council and indefatigable work. And not the least to be missed will be the pat and pert yarns that always illustrated Doctor Perkins' remarks.

FRED H. DRUMMOND, M.D.—COUNCILOR

■ President Brunk has appointed, the Council confirming, Fred H. Drummond, M.D., of Kawkawlin as Councilor to serve the unexpired term of Roy C. Perkins of the 10th district.

Doctor Drummond was born in Bay City, in 1892. He graduated from Western High School,

attended Albion College and graduated at Northwestern University Medical School in 1919; degrees of M.D., and B.S. in Medicine. He interned at Kansas City General Hospital 1919-20 and has practiced general medicine at Kawkawlin twenty-four years. He is on the staff (obst.) of Mercy and General Hospitals, Bay City; is past president, Bay County Medical Society; chairman of the Filter Board; member advisory committee of the Bay County Board of Supervisions; member of the American Legion and Sigma Chi.

Doctor Drummond brings years of service experience to his new position of responsibility. He has been assigned to the County Societies Committee.

OFFICERS RE-ELECTED

L. Fernald Foster, M.D., William J. Burns, LL.B., and Wilfrid Haughey, M.D., have been retained in their positions as Secretary, Executive Secretary, and Editor for another year.

ON THE RUN

Estrin therapy after the menopause will reactivate endometrial tissue.

• • •

The protection afforded by smallpox vaccination appears to be proportional to the area of skin inoculated.

• • •

In an infant, a history of inability to move the limbs should suggest either an obstetric paralysis, osteochondritis of congenital syphilis, or infantile scurvy.

• • •

Effective resuscitation in patients apparently moribund from hemorrhage, has been accomplished by transfusion of blood into an artery at a pressure of 160-200 mm. Hg., with simultaneous intratracheal oxygen insufflation of the lungs.

• • •

The human clavicle has been shown to rotate as much as 40 degrees when the arm is raised.

Selected by W. S. REVENO

Industrial Medical and Surgical Conference

RACKHAM MEMORIAL BUILDING

Farnsworth at Woodworth, Detroit

THURSDAY, APRIL 5, 1945, 10:00 A.M. TO 4:30 P.M. EWT

Third Annual Postgraduate Conference Sponsored by the Committee on Industrial Health of the Michigan State Medical Society, in co-operation with the Department of Postgraduate Medical Education of the University of Michigan.

General Chairman: K. E. Markuson, M.D., Lansing

Chairman of MSMS Industrial Health Committee

PROGRAM

Morning Meeting, 10:00 a.m.

Present-day Wartime Problems

1. "Industrial Medicine—Co-operation between Industrial Physicians and Private Practitioners" W. B. HARM, M.D.
E. A. IRVIN, M.D., Detroit
2. "Recent Developments under Michigan's New Compensation Law"
THEODORE P. RYAN, LL.B., Lansing
3. "Treatment and Prevention of Silicosis with Aluminum Powder"
DUDLEY A. IRWIN, M.D., Pittsburgh, Pa.

Recess for Luncheon

Afternoon Meeting, 2:00 p.m.

Postwar Problems of Industrial Health and Medicine

Leader of the Symposium.....RAYMOND HUSSEY, M.D., Baltimore, Md.

Subjects

1. "Selective Placement of Workers—A Personnel Manager's Viewpoint"
O. L. BEARDSLEY, Detroit
2. "Selective Placement of Workers—A Medical Man's Viewpoint"
S. E. POOLE, M.D., Burbank, California
3. "Psychosomatic Medicine in Industry"H. GRAHAM ROSS, M.D., Montreal, Canada
4. "Health Maintenance Engineering in Relation to Industrial Health"
MAJOR ROY P. WARREN, Sn.C., Baltimore, Md.

ADJOURNMENT AT 4:30 p.m.

All members of the Michigan State Medical Society are most cordially invited to attend this important Industrial Medical and Surgical Conference on April 5 in Detroit.

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Metamucil softens the fecal residue, protects intestinal mucosa and exerts a gentle, stimulating, physiologic peristalsis.

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RESEARCH IN THE SERVICE OF MEDICINE

Woman's Auxiliary

FIRST THINGS FIRST

For the second time the officers and county officers and county presidents of the Woman's Auxiliary were invited to attend the County Secretaries' Conference of the Michigan State Medical Society in Detroit, January 28. Here were learned the present trends in medical legislation and the effect the passage of such legislation would have on American society.



Our appreciation of the confidence placed in us by our parent organization should be shown by active endeavor in spreading this information throughout our counties and state. Be sure to offer your county medical society your full co-operation in this work and secure their approval of your plans of action.

This is of utmost importance to every one of us. Let us rearrange our schedule of activities and put FIRST THINGS FIRST.

(Mrs. H. L.) LELA FRENCH

RADIO SPEECH CONTEST

For the third year the Woman's Auxiliary to the Michigan State Medical Society was co-sponsor with the Michigan Tuberculosis Association in the Radio Speech Contest, a health project on Tuberculosis for Junior and Senior High School students.

This year forty-eight schools representing forty towns and cities in twenty-three counties entered the contest. The number of students participating were three thousand one hundred and two. The number of manuscripts submitted and qualified was eighty-nine.

Local school winners spoke before thirty-three local audiences with a total attendance of two thousand seven hundred and forty-three. Fourteen local programs were presented over eight radio stations. The total radio time was three hours and a half.

First place winners broadcasted over WKAR, Michigan State College radio station, for one-half hour, December 14, 1944.

The State winners and the subject of their manuscripts were:

Ruth Borsum, Newberry High School—"The threats and Contributions of the Present War in Tuberculosis Control." Ann Kontas, Sexton High School, Lansing—"The Christmas Seal in the Fight to Prevent Tuberculosis." William Bier, Ironwood High School, "Tuberculosis Eradication—A Possibility." John LaForge, Ironwood Junior High School, "Tuberculosis and Me."

Second place winners were: Kathleen Essenberg, Holland High School; Ida Polito, Algonac High School; Margaret Hartley, Vassar High School; Lois Cramer, Fairgrove High School.

Medals were presented to the winning students by

Mrs. Horace L. French. The judges of the contest were: Prof. Paul Bagwell, Speech Department, Michigan State College; Miss Elaine Abbott, Field Representative, Michigan State Tuberculosis Association; Mrs. Horace L. French, President of the Woman's Auxiliary to the Michigan Medical Society.

MRS. MILTON SHAW,
Radio Speech Contest Committee

BULLETIN

Mrs. Homer A. Ramsdell, Chairman of *The Bulletin*, 514 Oak Street, Manistee, reports that on February 5, she had ninety-six subscriptions to *The Bulletin*, all of the old subscriptions have been renewed and there are 41 new subscriptions. Subscribe to *The Bulletin* of the Woman's Auxiliary to the American Medical Association. It is issued quarterly at the rate of one dollar (\$1) per year. Send your subscriptions direct to Mrs. Ramsdell.

BAY COUNTY

The Woman's Auxiliary to the Bay County Medical Society held its December meeting at the home of Mrs. J. H. McEwan, Wednesday, December 13.

Following dessert, Mrs. C. L. Hess, president, conducted the business meeting. Miss Ann Ballou reviewed "The Immortal Wife," which was very interesting. About half the members had been requested to bring something for a bazaar and the money made will be used for subscriptions to *Hygeia* in thirteen Bay County schools.

* * *

The Woman's Auxiliary to the Bay County Medical Society held its January meeting at the home of Mrs. Robert H. Criswell, Wednesday, January 11.

Following dessert, Mrs. C. L. Hess, president, conducted the business meeting. There were twenty-five members present.

A musical program followed. Mr. Walter A. Valentine, baritone, sang a group of vocal solos and Mr. Frederic Boehringer offered a group of piano solos.

DELTA-SCHOOLCRAFT COUNTIES

Mrs. Donald H. Boyce was elected president of the Auxiliary to the Delta-Schoolcraft Medical Society at the annual election held at a tea of attractive appointments in the home of Mrs. Louis P. Groos. Chosen to serve with Mrs. Boyce are Mrs. William A. LeMire, Jr., president-elect; Mrs. A. J. Carlton, secretary; and Mrs. Louis P. Groos, treasurer.

"AMERICAN MEDICINE"

The MSMS Radio Program
Station WJR

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Yes"



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Primarily, TAMPAX meets *all* the requirements of modern menstrual hygiene — since (as one specialist summarizes) "the evidence is conclusive that the tampon method of menstrual hygiene is safe, comfortable and not prejudicial to health..."³

Indeed, so comfortable is "flat expansion", provided only by TAMPAX, that many women are hardly aware of its presence *in situ*.¹ Welcome freedom from external bulkiness, vulval irritation or chafing from perineal pads, allows the patient a wider range of activity during the period. An individual applicator permits easy insertion, and a moisture-resistant cord facilitates dainty removal.

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REFERENCES — 1 West. J. Surg. & Gyn., 51:150, April, 1943. 2 Clin. Med. & Surg., 46:327, August, 1939. 3 Med. Rec., 155: 316, 1942. 4 Crossen, H.S. and R. J.: Diseases of Women, C. V. Mosby Co., St. Louis, 9th ed., 1941.

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What's What

Major Emil Joseph Genetti of Bessemer, Michigan, and Major Douglas Donald of Detroit, Michigan, have been promoted to the rank of Lieutenant Colonel.

* * *

Wilfrid Haughey, M.D., Editor of THE JOURNAL, spoke at the Youth Forum of Olivet College, Sunday, February 11, on Political Medicine.

* * *

Howard P. Doub, M.D., Detroit, is the author of an original article "Aseptic Necrosis of the Epiphyses and Short Bones," which appeared in JAMA of February 10, 1945.

* * *

D. J. Leithauser, M.D., Detroit, is the author of an article in JAMA under Clinical Notes, Suggestions and New Instruments. Dr. Leithauser describes "A Simplified Suction Unit for Intestinal Decompression."

* * *

Paul D. Bagwell, Professor and Head of the Speech Department, Michigan State College, addressed the Genesee County Medical Society on February 21. His subject was "Proposed Amendment to the Constitution of the State of Michigan."

* * *

The American College of Surgeons has deferred for the time being its 1945 series of War Sessions, four of which were to have been held in February, according to an announcement by Dr. Irvin Abell, chairman of the Board of Regents.

John Alexander, M.D., of Ann Arbor has been appointed as one of the 14 medical men to serve on the Veterans' Special Medical Advisory Board. This group will guide General Hines in establishing policies and in solving the problems that will develop in the examination and treatment of returning veterans of this war.

* * *

Stanley Maynard, of Chicago, an executive of the Research Institute of America, in an address at Grand Rapids on January 18, 1945, made the prediction that "we will not have socialized medicine, no guaranteed annual salary for labor, and that unemployment may reach 10 to 12 million between the first and second phase of the postwar era."

* * *

The New Cover.—The Editor asks the membership: "How do you like the new cover of THE JOURNAL of the Michigan State Medical Society?"

Each month, THE JOURNAL cover will feature a pen-and-ink sketch of a living past-president of the Michigan State Medical Society. The art work is the creation of Phil Steele, well-known Chicago artist and illustrator.

* * *

The American College of Surgeons has approved Hurley Hospital for Graduate Training in Surgery. A program has been organized in medical education which when put into effect will consummate an affiliation with
(Continued on Page 294)



"AMERICAN MEDICINE"

The MSMS Radio Program

Station WJR

Every Friday, 7:15 to 7:30 p.m. EWT

Invite Your Patients to Tune In

Don Douglas acts as narrator on these programs. He is assisted by the artists shown in the photograph—George Dorn, tenor, Althea Haglund, soprano, Jimmie Clark, organist.

5

5 Separate VI-SYNERAL Products For 5 Different Age Groups

Years before official government sources promulgated the different daily vitamin-mineral requirements for different age groups, Vi-Syneral was developed to provide 5 separately balanced vitamin potencies—fortified with minerals—for each of 5 main age groups.

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the Medical School of the University of Michigan for teaching in the Basic Sciences in conjunction with the Graduate Training in Surgery at Hurley Hospital. The clinical training in such a program will be given at Hurley Hospital, Flint, Michigan, and the Basic Science instruction will be given at the University of Michigan Medical School in residentia.

* * *

One out of every ten babies born today is being cared for under the EMIC Program, according to the Children's Bureau's announcement to the press. A total of 300,000 infants were born with the help of the Emergency Maternity and Infant Care Program, during the 20 months of the EMIC operation. Each month another 40,000 authorizations are added.

The current appropriation for the case is \$42,800,000!

* * *

The use of color in medical advertising is increasingly apparent in THE JOURNAL of the Michigan State Medical Society. Every issue contains more two- and four-color advertisements, color spreads (two pages), and bleeds.

Advertising (which in medical journals was once considered the stepchild of the publication) now has assumed its rightful Cinderella-like position as an aid to the beautification of and interest in the medical paper.

* * *

The famous (or infamous) Wagner-Murray-Dingell Bill died with the adjournment of the last Congress. However, Representative Dingell ("ring the bell with Dingell") of Michigan lost no time in re-introducing the identical measure (H.R. 395) on January 3, 1945. The 78th Congress now has the opportunity, in Mr. Dingell's bell-ringing bill, to provide everything for every individual in the United States, from "the cradle to the grave," whether said individual wants it or needs it or not!

* * *

The Veterans Administration estimates that Public Law 346, approved June 22, 1944 (GI Bill of Rights), will provide from \$4 to \$6.5 billion government funds to aid World War II veterans to adjust themselves to civilian life. Estimate roughly indicates that for each *one million* persons in uniform there will be a cost of slightly less than \$450 million within first 7 years after hostilities cease. Veterans Administration estimates educational costs alone will probably range from \$2.5 to \$3.8 billion.

* * *

United States Gross Federal Debt in 1939 was \$40.4 billion. By mid-1945 this is scheduled to top \$250 billion. This slightly *more than six times increase* represents growth of OUR national gross debt under three and one-half years of war.

Great Britain's National Debt in 1939 amounted to \$33.6 billion and by mid-1945 will probably top \$93.5 billion. This slightly more than two and one half times *increase* represents growth of Britain's debt under a *five-year* war.

(Continued on Page 296)



Case is solid walnut with black bakelite operating panel. Illustration includes No. 961 Sub-Cabinet.

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Rubber capped multiple dose vials.

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A. W. Lescohier, M.D., president of Parke, Davis & Company, has been elected chairman of the Wayne University Foundation for 1945. The Foundation was established in 1938 to act as trustee for the receipt, management, and disbursement of grants and gifts to the University, which is located in the City of Detroit, and which now ranks twelfth in size among the colleges and universities of the United States. Dr. Lescohier is a graduate of the College of Medicine of the University, and in 1937 was the recipient of the honorary degree of Doctor of Science.

* * *

St. Mary's Hospital, Detroit, will celebrate its Centennial Anniversary on May 16 and 17. The program tentatively is a Clinic on May 17 to which have been invited Alexander Brunschwig, M.D. of Chicago, Russell Cecil of New York and Emil Novak of Baltimore.

The Clinic will be followed by a dinner, including a reunion of interns trained at the Hospital.

Further details on the Centennial Anniversary program of St. Mary's Hospital will be announced later. All members of the Michigan State Medical Society are cordially invited to be present at the functions of this Centennial Anniversary.

* * *

The Torch Club of Battle Creek on January 16, 1945 conducted a panel discussion of "Socialized Medicine." The panel consisted of the president of one of our denominational colleges, two doctors of medicine, a Major in the Veterans Administration, the pastor of a Congregational church, and a brilliant colored attorney. Much time was lost in definition, but discussion set forth both sides of the subject, and brought out what the Michigan State Medical Society has done and is doing to meet the needs of the people in a democratic way, and the belief of labor that medical care is too expensive as at present administered. The leader of the panel summed up to the effect that both sides seemed to have proved their points. Upon a suggestion by one of the doctors that he never thinks of "socialized medicine," but always thinks of it and calls it by its true name of "political medicine," the decision was rendered, "That wins the argument."

* * *

The Pepper Sub-Committee on Wartime Health and Education proposes the creation of health centers in every community to combine preventive, diagnostic, and curative care and to operate as part of an integrated system of local, district and metropolitan state hospitals. The system would consist of four basic types of medical care facilities: the small neighborhood or community "health center," the rural hospital, a district hospital, and a large state hospital.

The Sub-Committee has concluded that the fee-for-service method of meeting medical expenses tends to keep patients from doctors until illness is so severe that medical bills are large. Voluntary pre-payment, compulsory insurance, tax supported medicine or a combination of these methods were cited as possible al-

(Continued on Page 298)

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The Sub-Committee feels that action is overdue and should not be delayed.

* * *

Miner Memorial Fund

Established at Wayne

A \$10,000 scholarship fund for medical students has been established at Wayne University by Mrs. Marion M. Leahy and Helen I. Miner as a memorial to their father, the late Dr. Stanley G. Miner.

Born in Detroit in 1861, Doctor Miner was a graduate of the Wayne University College of Medicine and served on its faculty as professor of otology, laryngology, rhinology, and physical diagnosis. He also was a member of the staff of St. Mary's Hospital and was at one time chief of staff for that institution.

* * *

Board Accepts

Gifts to Wayne

An investigation of the value of penicillin in the treatment of early syphilis will be undertaken at the Wayne University College of Medicine following the acceptance by the Board of Education at its last meeting of the sum of \$3,793 offered by the Federal Office of Scientific Research to finance the project. The study will be directed by Dr. Loren W. Shaffer, professor of dermatology and syphilology in the Wayne University College of Medicine.

Other gifts accepted include a \$280 grant offered by the American Medical Association for a study on alloxan diabetic coma to be conducted by Dr. Harry M. Weaver, assistant professor of anatomy.

* * *

Bill in Congress Would Create Medical Academies

Mr. Dickstein of New York recently introduced H.R. 713 into the National Congress which proposal provides for the creation of one medical academy in each corps area in the United States, each to enroll a minimum of 295 students to be selected by U. S. Senators and Representatives, with vacancies filled by the Commanding General of the Army Corps. Upon completion of the course of study, the candidates are to be commissioned in the Army, Navy, or Public Health Service to continue said service for at least ten years—unless it shall be certified that there is no further need for their services.

This would mean that graduates of the "Medical West Points" would not retire from military service until they reach the approximate age of thirty-seven or thirty-eight. It is doubtful that many would seek private practice after that age.

* * *

S. 191 introduced into the Federal Congress by Mr. Hill of Alabama and Mr. Burton of Ohio, proposes a survey of hospital service and facilities in the United States (\$5,000,000), and the construction and maintenance of necessary hospitals and health centers (\$500,000,000).

(Continued on Page 300)



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S. 190 introduced by Mr. Murray of Montana (famous as a member of the Wagner-Murray-Dingell triumvirate) would aid in co-ordinating research relative to dental diseases and conditions and would establish the National Institute of Dental Research. This bill was prepared by the dentists and is most heartily approved by them. Besides research, it would provide fellowships in the National Institute of Dental Research from funds appropriated or donated by government, and it would also co-operate with state health agencies in the prevention and control of dental diseases and conditions. An appropriation of \$1,000,000 is asked for the erection and equipment of suitable and adequate building facilities and \$730,000 for each fiscal year thereafter beginning June 30, 1946.

* * *

Council and Committee Meetings

Annual Session of the Council—Book-Cadillac Hotel, Detroit, January 25-26-27, 1945.

Medical Advisory Committee on Physical Rehabilitation—Porter Hotel, Lansing, January 7, 1945.

Industrial Health Committee—David Whitney House, Detroit, January 17, 1945.

Mental Hygiene Committee—David Whitney House, Detroit, January 25, 1945.

Medical Advisory Committee on Physical Rehabilitation—Book-Cadillac Hotel, Detroit, Jan. 25, 1945.

Public Relations Committee—Book-Cadillac Hotel, Detroit, January 27, 1945.

Committee on Procurement and Assignment Service for Doctors of Medicine—Book-Cadillac Hotel, Detroit, January 27, 1945.

Committee on Venereal Disease Control—Porter Hotel, Lansing, February 11, 1945.

Special Committee on Radio—David Whitney House, Detroit, February 14, 1945.

Special Contact Committee with Michigan Crippled Children Commission—Book Cadillac Hotel, Detroit, February 20, 1945.

Executive Committee of The Council—Book-Cadillac Hotel, Detroit, February 21, 1945.

Legislative Committee—David Whitney House, Detroit, February 22, 1945.

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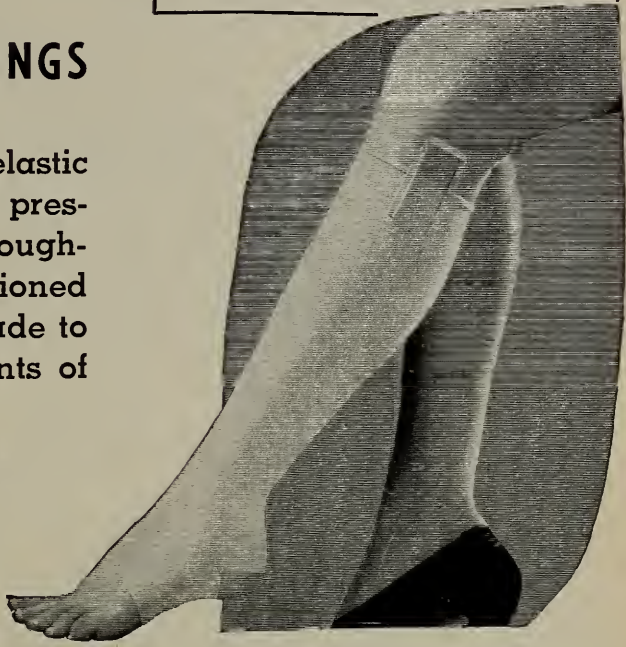
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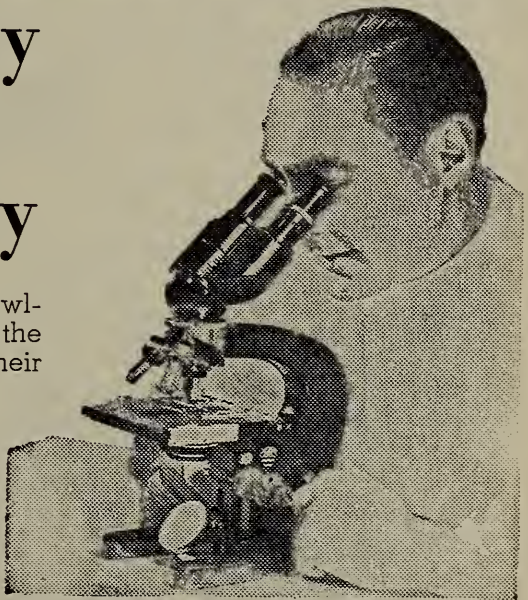
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MEDICAL USES OF SOAP, A Symposium. Edited by Morris Fishbein, M.D. 41 illustrations. Philadelphia. J. B. Lippincott Company, 1945. Price \$3.00.

Ten authors contribute to the formation of this book on soap. The chemistry of soap, the various kinds, the properties and action, and the methods of manufacture are given. Other cleansing agents are described which are not soaps. Pictures are given showing skin diseases that are relieved by soap, and those made worse. The itching of seborrheic dermatitis of the scalp is immediately relieved. The care of the normal scalp is given. Effects of soaps on razor blades, and the therapeutic use of shaving are given attention. The book is a relaxation, and a source of valuable information.

CONTROL OF PAIN IN CHILDBIRTH. By Clifford B. Lull, M.D., F.A.C.S., Clinical Professor of Obstetrics, Jefferson Medical College; Assistant Director, Philadelphia Lying-in Unit, Pennsylvania Hospital; and Robert A. Hingson, M.D., Surgeon, United States Public Health Service; Director, Postgraduate Medical Course, Philadelphia Lying-in Unit, Pennsylvania Hospital, with an introduction by Norris W. Vaux, M.D., Obstetrician-in-Chief, Philadelphia Lying-in Unit, Pennsylvania Hospital. 100 Illustrations in Black and White

(Continued on Page 304)



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and 32 subjects in color. Philadelphia: J. B. Lippincott Company, 1944. Price \$7.50.

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MODERN CLINICAL SYPHILOLOGY. By John H. Stokes, M.D., Professor of Dermatology and Syphilology, School of Medicine and Graduate School of Medicine, University of Pennsylvania; Director, Institute for the Control of Syphilis, University of Pennsylvania; Herman Beerman, M.D., Sc.D. (Med.), Assistant Professor of Dermatology and Syphilology, School of Medicine and Graduate School of Medicine, University of Pennsylvania; and Norman R. Ingraham, Jr., M.D., Assistant Professor of Dermatology and Syphilology, School of Medicine, University of Pennsylvania. Third Edition, Reset. 1332 pages with 911 illustrations. Philadelphia and London: W. B. Saunders Company, 1944. Price \$10.00.

Syphilology has become a specialty of itself, requiring whole text books as ponderous as used to cover the whole field of Internal medicine. The disease is completely covered, diagnosis, treatment, control, complications. Much space is devoted to treatment planning, fundamental principles, heavy metals, iodides and arsenicals. The late treatment, chemotherapy and pen-

(Continued on Page 306)

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icillin are included. Also the study of neurosyphilis is given prominence. Diagrams, tables and multitudinous illustrations help one to understand the disease. This text is complete, up to the minute, and includes public health and war influences. Not only specialists but every one who treats syphilis should have this work at his command.

THE PATHOLOGY OF INTERNAL DISEASES. By William Boyd, M.D., LL.D., M.R.C.P., Ed., F.R.C.P., Lond., D.P.H., Psych., F.R.C.S., Professor of Pathology and Bacteriology in the University of Toronto; Formerly Professor of Pathology in the University of Manitoba, Winnipeg, Canada. Fourth Edition, Thoroughly Revised. Octavo, 857 pages. Illustrated with 366 engravings and 8 colored plates. Philadelphia: Lea & Febiger. December, 1944. Cloth \$10.00.

The principal aim in preparing this fourth edition is to bring out the new knowledge concerning the pathological changes in many diseases, but particularly heart disease. Special attention is given to rheumatic fever, coronary infarcts, hypertension. New is the demonstration of the auxiliary coronary circulation by injection, and many other heart conditions; the relation of trauma to coronary thrombosis. Much new material deals with primary atypical pneumonia, Q fever, psittacosis, fuel oil pneumonia, hemangioma of the lung and blast injury. In a single volume is given the relations of anatomy, histology and physiology to the problems of every practitioner. The causes and changes in internal disease are given, with a tracing of

(Continued on Page 308)

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Every phase of etiology, epidemiology, pathology, symptomatology, complications, sequelae, clinical and laboratory diagnosis, prognosis, prophylaxis, and treatment is well covered. Definitions and descriptions are clear, with sufficient illustrations. The treatment is outlined so as to afford a good working reserve, and complications are also included. This compendium is well worth its cost, and is so arranged as to be easily consulted.

THE 1944 YEAR BOOK OF INDUSTRIAL AND ORTHOPEDIC SURGERY. Edited by Charles F. Painter, M.D., Orthopedic Surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. Chicago: The Year Book Publishers, 1945. Price \$3.00.

The authors have abstracted all the leading articles of the year bearing upon the subject-matter of orthopedic and industrial surgery. These abstracts are from a half page to several pages, and give the meat of the article, thus making available the latest thought on the subject, and keeping the reader well posted in a way impossible by individual reading. References

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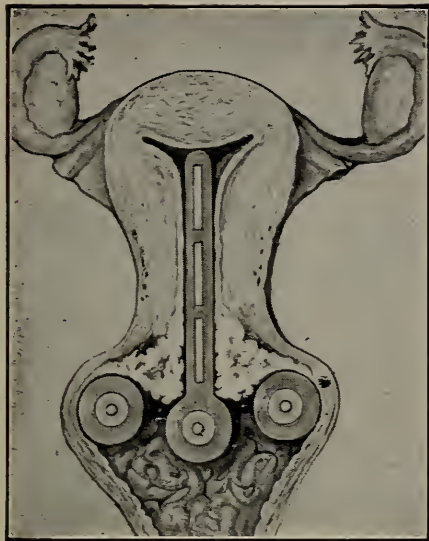
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re given to the original paper, and a good index is provided. The Year Book is always a comprehensive material source, and this one is no exception.

ANATOMY OF THE HUMAN BODY: By Henry Gray, F.R.S., Late Fellow of the Royal College of Surgeons; Lecturer on Anatomy at St. George's Hospital Medical School, London. Edited by Warren H. Lewis, B.S., M.D., member, The Wistar Institute of Anatomy and Biology, Philadelphia, Pennsylvania. Associate Editors: Earl T. Engle, Ph.D.; Joseph C. Hinsey, Ph.D.; Normand L. Hoerr, Ph.D., M.D.; Karl E. Mason, Ph.D.; David McK. Rioch, M.D., and Roy G. Williams, M.D. Twenty-fourth edition, thoroughly revised. Illustrated with 1,256 engravings. Philadelphia: Lea & Febiger Company, 1944.

Gray's Anatomy is always a necessity for any practitioner of medicine. This new twenty-fourth edition is of the same high standard that has made this work a classic. New things have been added; new editors have brought new ideas. This monumental new edition is now available.

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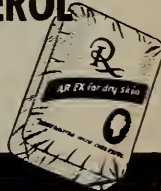
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THE WRONG WEATHER MAP

(Continued from Page 232)

he talents that are available to the army medical corps at present. It would still have the inescapable stupidity of bureaucracy, intensified by a permanent bureaucratic personnel whose members' chief interest inevitably becomes that of avoiding trouble, escaping decisions, and thereby continuing to draw their pay.

A hospital might need air conditioning, it might need a new sterilizer, it might need additional beds, but if its need didn't fit into the preconceived notions of Washington, based on some weather map or statistical table, it wouldn't get them and the people it was expected to serve would suffer. This country is too big and too complex to be run from Washington.

Editorial, *Chicago Tribune*, Dec. 31, 1944.

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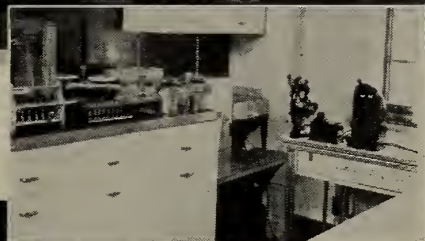
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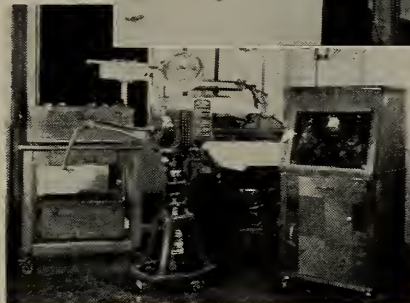
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You and Your Business

ONLY 24,000 TO RETURN?

Dean A. C. Furstenberg of the University of Michigan presented some interesting but startling information to the Executive Committee of The Council of the Michigan State Medical Society at its February meeting. In discussing postwar postgraduate work, Dr. Furstenberg stated that postwar education is an important but abstruse subject; no one knows how many persons will seek assistance or to what extent their needs will be in this endeavor. Two main groups must be served:

(a) The young doctor of medicine who has had his education interrupted or abbreviated.

(b) The older man who wants refresher courses prior to return to practice or prior to entering a specialty.

For the former, the educational institutions are planning expansion of their graduate medical education programs. For example the University of Michigan is increasing its facilities to the care of approximately 200 graduate students. However, this will not meet the requirements and the job cannot be done alone by the medical schools. So, in order to organize the extensive programs that will be needed, the medical schools should affiliate with teaching hospitals, most importantly for work in basic sciences.

For board certification, the doctor of medicine will probably be required to have one year's internship, one year in applied sciences and a term of residency (two to four years) in an approved hospital. Approved hospitals must have a responsible participation in this program.

Refresher courses for older men returning to practice: The University of Michigan is offering three courses: (a) two months of applied basic sciences; (b) two months in all the various fields of medical practice; and (c) two months of specialization in medicine.

The applicant may take any one, or two, or all three of these courses.

Re the need for postgraduate work: Dr. Furstenberg stated that according to some recent statistics one is surprised to note that a great many doctors will perhaps be needed in future years for the national services. He based this state-

ment on the supposition that 36,000 of the present 60,000 doctors in military service (47,000 in the Army and 13,000 in the Navy) may be utilized after the War's end in the following capacities: 4,000 in the USPHS, 8,000 in the occupied territories, 8,000 in the compulsory military training program, 8,000 in the veterans administration, and 8,000 basic complement for standing army. Thus, 24,000 medical officers might be expected to return to civilian practice.

Dr. Furstenberg ventured the prediction that the plateau of demobilization of medical officers for the Army would be in 1948 and for the Navy in 1950.

MMS-MHS PROTECTION BROADENED

Effective May 1, completely new certificates greatly broadening the protection of enrolled doctors and their office employes will be issued by Michigan Hospital Service and Michigan Medical Service.

The new certificates make the hospital service virtually all-inclusive for the average case and extend the surgical plan in several respects. They will be provided at a moderate increase in rates for the hospital protection and at no increase in rates for the surgical protection.

Typical of the new hospital plan benefits which will be made available to Blue Cross bed patients are: an increase in the number of full days' service from 21 to 30, the provision of the same amount of care for every disability rather than a limitation of care by the year, and the addition of such former "extras" as basal metabolism examinations, accident room care, physical therapy, extensive laboratory service and penicillin.

The most important change in the surgical plan is the addition of a provision for accident care. The new benefits are being added at the request of many members. The additional benefits are designed to serve two purposes:

To reduce to a minimum the likelihood that Blue Cross members will have to pay hospital "extras."

To make extra provision for long or repeated hospitalizations.

(Turn to Page 320)



Warren-Teed Acceptances

which have been announced by the American Medical Association's Council on Pharmacy and Chemistry —

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TYRAMINE
HYDROCHLORIDE

25 mg. Capsules
EPHEDRINE
HYDROCHLORIDE

50 mg. Capsules
EPHEDRINE
HYDROCHLORIDE

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Tablets
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AMINOPHYLLINE

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NICOTINIC ACID

50 mg. Tablets
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NICOTINAMIDE

1 mg. Ampule 1 cc.
DIETHYLSTILBESTROL

1 mg. per cc.
15 cc. R.S. Vials
DIETHYLSTILBESTROL

10 U.S.P. Units per cc.
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DISPOSING OF RECORDS OF DECEASED PHYSICIANS

After his death, the medical records of a doctor of medicine may be disposed of in three ways: (a) they may be destroyed; (b) they may be transferred to another physician; (c) they may be given to former patients.

J. W. Holloway, Jr., Director of the Bureau of Legal Medicine of the American Medical Association, feels it would be wise for an estate to pursue the following procedure in disposing of a doctor's records:

"Destroy the records of deceased patients after they have been retained possibly until the time has elapsed within which suit for malpractice may be instituted or until their value in connection with unpaid bills has ceased to exist.

"Send a brief notice to patients still alive, or their parents or guardians, advising of the physician's death and stating that the records of the deceased physician will be destroyed after a stated period unless a request is received asking that they be transferred to another attending physician.

"While there is no legal obstacle to the transfer of records to the patients themselves, such procedure, however, does raise professional questions as it is not advisable in many instances for patients to have access to a physician's records because of the danger of misunderstanding, misinterpretation or hysteria."

RE-ENROLLMENT OF M.D.'S DURING APRIL

During April, all members of the Michigan State Medical Society will receive information about the new program from Michigan Medical Service and Michigan Hospital Service. Mailed to them about the same date will be material offering enrollment in both the hospital and surgical plans to their office employees.

Doctors who are now enrolled in Michigan Hospital Service will receive by mail copies of their new certificates and folders explaining their new benefits, together with their bills for the next six months' payment.

Doctors who are not enrolled will receive a folder explaining the hospital plan, and an application card, offering them the opportunity to enroll. They will also receive in the same envelope a folder explaining the hospital and the surgical plan for their office employees.

Office employees who are now enrolled in Mich-

igan Hospital Service and Michigan Medical Service will have the opportunity to adjust their service to provide for births, deaths, return from military service, or other changes in their family status.

To these office employees who are now enrolled will be mailed folders explaining the new benefits, their new certificates, and their bills for the next six months' payment.

Office employees not enrolled in either of the plans will have an opportunity to apply for enrollment. As stated above, explanatory literature for them will be sent to the doctors by whom they are employed.

The closing date for changes in service and for enrollment, for both doctors and their office employees, is April 25. By that date Michigan Medical Service and Michigan Hospital Service must have in their offices all requests for changes in service and applications for enrollment, accompanied by the payment for the next six months period.

Instructions for making changes in type of service will accompany the literature sent to members.

Effective date on the new certificates will be May 1.

ONLY A FREE SCIENCE CAN PROGRESS

All here are aware that medical practice has an economic status, and that the relationship of medical practice to health and wealth has been under review and attack, representation and misrepresentation, for a long time. You will agree with me that the attack on the present concept of medical practice has taken its most violent form in the Wagner-Murray-Dingell Bill, which would do this:

Increase payroll taxes—taxes on you (6 per cent on you and 6 per cent on your employer which eventually means 12 per cent on you; if you are self-employed, the tax is raised to 7 per cent on you; however, if you are a bureaucrat—an employe of the government, the tax will be only 3½ per cent).

Place \$3,048,000,000 in the hands of one man (the U.S.P.H.S. Surgeon General) to spend annually.

Permit the hiring of 150,000 more federal bureaucrats. Not guarantee better medical care. In fact, experience in other countries shows that the quality of medical care disintegrates under government "protection."

How can we provide medical care for everyone? The dean of School of Medicine at St. Louis University (Alfonse M. Schwitalla, S.J., who is *not* a Doctor of Medicine), gives this answer to the question: "Provide

(Continued on Page 324)

ERTRON *in Arthritis*



Ertron*, differing from any previous agent employed in the treatment of arthritis, has been singularly effective against this common affliction.

Now, after a decade of intensive investigation in hospital, laboratory, clinic and private practice, the vast number of articles in foremost medical journals testify to the value of Ertron.

SPECIFY ERTRON

In the large list of bibliographic references, the importance of both safety and effectiveness is stressed. Quite consistently it is mentioned that the Whittier Process product—Ertron—has the essential features of non-toxicity and successful therapeutic response.

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To Ertronize the arthritic patient, employ Ertron in adequate dosage over a sufficiently long period to produce beneficial results. Gradually increase the dosage to the toleration level—maintain this dosage until maximum improvement occurs.

Ertron alone—and no other product—contains electrically activated vaporized ergosterol (Whittier Process). It is the product which numerous investigators have repeatedly shown to be effective and nontoxic in recommended dosages.

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*Reg. U. S. Pat. Off.

**NUTRITION RESEARCH LABORATORIES
CHICAGO**

ONLY A FREE SCIENCE CAN PROGRESS

(Continued from Page 320)

people with adequate wages, reduce indigency, and everyone will be able to secure medical care when it is needed, how it is needed, and from whom it is needed. When I am sick, I want *my* doctor; when you are sick, you are entitled to your doctor, to the hospital of your choice and from the nurse of your choice. Don't blame medicine for your economics. If medicine 'goes economics,' it may have no time to be good medicine and then 'God Help America.'"

What is really more important and of far greater interest than the Wagner-Murray-Dingell Bill or any of its kind—such as the proposed initiative amendment to the Constitution of the State of Michigan—is whether medical practice is sound as it is made available today, or does it require sweeping changes?

Today's practice—under the American system of private medical care—is the most effective plan yet devised. It has attained the highest results. For example, in 150 years, the average number of years a man will live has been nearly doubled; in 1790, the average was thirty-five years—today it is sixty-two years. A child born in 1942 has the prospects of living twelve years longer than a child born in 1900.

During the past forty years, typhoid fever almost has disappeared; smallpox has been subdued; diphtheria practically has been conquered; pernicious anemia, tuberculosis, diabetes, and a score of lesser ailments are being brought under control. According to the Surgeon General of the U.S.P.H.S. himself, in 1942, the United States—at war—had the highest general level of health and the lowest death rate ever known for a like number of people under similar conditions.

These high attainments have been made by a free science. *Only a free science can progress. Political control will keep it in chains.*

Two principles are involved:

1. To permit the present program to progress with supplementary features to fill needs in various localities; or
2. To permit political control, operation, and a chained and non-progressive science.

In speaking of supplementary features, I invite your attention to a Michigan program which has been eminently successful and is being copied in all parts of this country. It is our *voluntary* group medical care plan, called "Michigan Medical Service." This is a budgeting system solving a fundamental portion of the payment problem which faces the public—the catastrophic type of illness which wipes out reserves; it is solving the problem without regimentation of the people, without more federal bureaucracy, and without more red tape at a time—when you are ill—that delay can be dangerous. Michigan Medical Service is a non-profit, pre-payment plan, sponsored by the Michigan State Medical Society in 1940. Now after only four years of existence, this voluntary program has already 700,000 subscribers—one out of every eight Michigan residents being covered by a budgeting system against

unforeseen medical catastrophies. Thirty-seven programs of this type already exist in twenty-two of the states of this nation.

The people want payment for medical care made easy. They do not want taxation as such and it is most unlikely that they favor more federal control. The answer lies in the voluntary activity as grandly exemplified by Michigan Medical Service, created by the Doctors of Medicine in this state at great expense of effort, hard work and money.

I believe that most people in this country want to maintain American standards and American customs. They prefer voluntary systems to compulsory rule. They don't like to be bossed by officials. They agree with Winston Churchill who said: "Let us beware of trying to build a society in which nobody counts for anything except a politician or an official, a society where enterprise gains no reward and thrift no privileges."

VOLUNTARY NONPROFIT INSURANCE

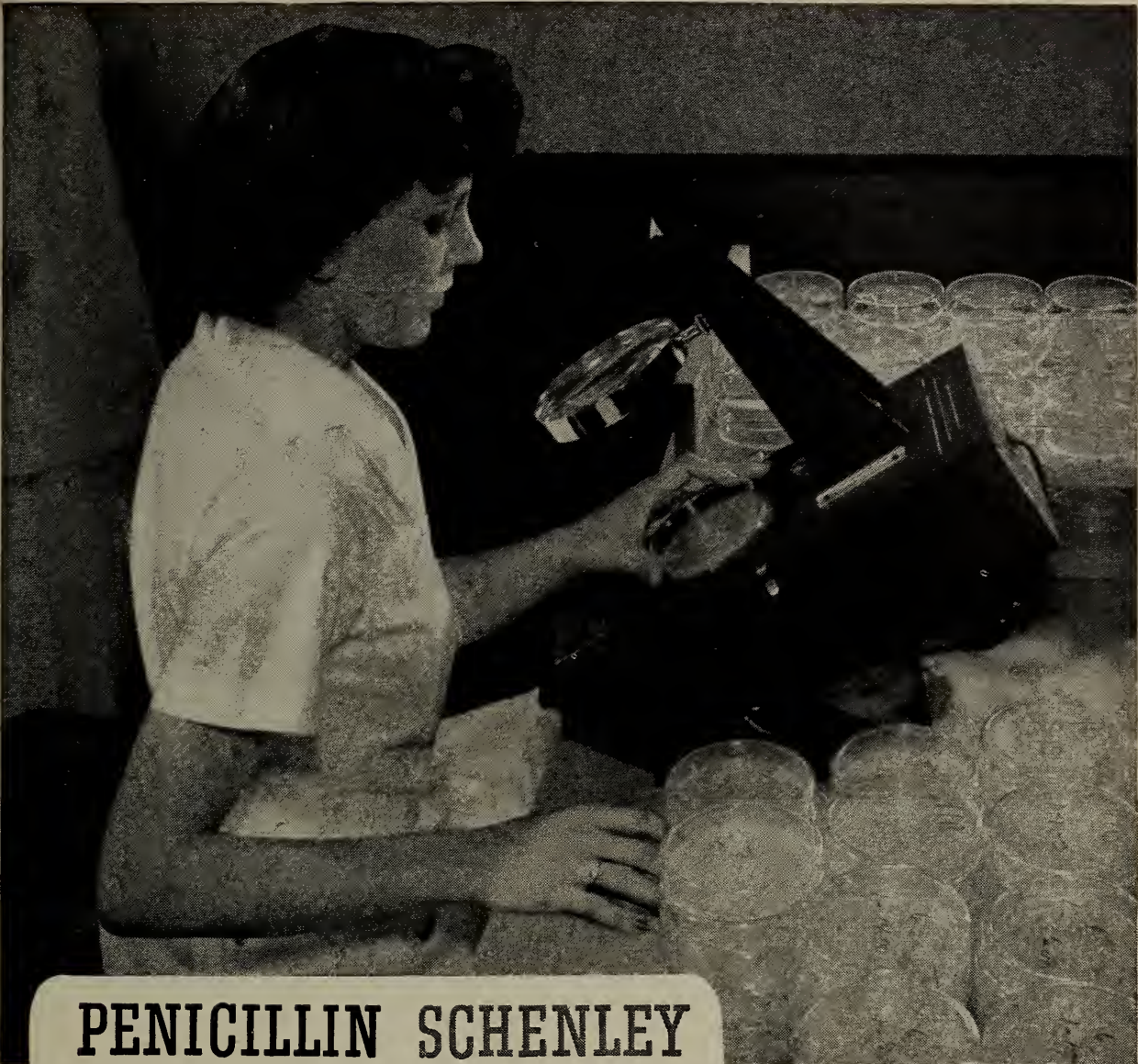
Unless doctors do interest themselves in *voluntary* insurance, and join hands with other groups which are becoming interested, they need not be surprised some fine day to wake up and read in their favorite morning paper that Congress has passed a bill creating a Commissar of Medicine and providing for a gigantic tax fund to finance a system of compulsory health insurance. And they may expect, also, for the indigent poor to be left on the doorsteps of the doctors, just as they always have been.—Editorial, *North Carolina Medical Journal*, December, 1944.

SENATOR PEPPER'S COMMITTEE, AND MEDICAL SERVICE PLANS

The President of the United States has expressed himself in favor of socialized medicine. Senator Pepper, a notorious proponent of change, has advocated any kind of a start to get going, and declared, "I'm going to make a speech in the Senate at least once a week until something is done." The Surgeon General of Public Health, Dr. Thomas Parran, said, "It now seems certain that in the postwar period the people of the nation will demand and get more complete medical, public health and hospital care. Almost certainly this care will be purchased through some type of pre-payment plan." The A F of L desires Parran's proposals to be converted into legislation by the Pepper Committee. In pending legislation there is the Wagner Bill and in California a bill now in the legislature providing compulsory medical care for everyone in the state. La Guardia has launched a plan to cover 190,000 municipal employes in New York City. As a counter-move United Medical Service (physician sponsored) has 50,000 persons covered.

Now, as the conservatives repeatedly asseverate, the record of American medicine is superlatively good: The life span has increased twenty years since the turn of the century. The death rate per thousand has decreased from 17.2 to 10.8. Notwithstanding the current shortage of doctors, maternal death, infant mor-

(Continued on Page 326)



PENICILLIN SCHENLEY

— the drug that gives new meaning to the word "control" —

The penicillin which first attracted the attention of Alexander Fleming was an "occurrence of nature", with no control exercised over the conditions of its production. Production of pyrogen-free penicillin for the medical profession, however, is accomplished only by the most elaborate methods of control for insuring highest attainable productivity, potency, and purity.

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SENATOR PEPPER'S COMMITTEE*(Continued from Page 324)*

tality and tuberculosis are at an all-time low. Diphtheria, typhoid, smallpox and a host of other diseases have been reduced to record minimums or are almost non-existent.

The cost of complete prepaid family coverage, owing to inherent abuses, is prohibitive. Even with salaried physicians Kaiser's cost was \$13.40 per family a week. With free choice of physician it would be even higher. A man earning \$3,000 a year can't pay \$180 or 16 per cent of his income for medical care. Moreover, complete coverage would increase enormously the number of office and house calls and the number of patient hospital days. The sky is the limit and it invites abuses as does a "cost plus" contract.—C. A. Veasey, Jr., M.D., Spokane County Medical Society, February, 1945.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATIONS

The general oral and pathology examinations (Part II) of the American Board of Obstetrics and Gynecology for all candidates will be conducted at Atlantic City, New Jersey, by the entire board from Thursday, June 14, through Tuesday, June 19, 1945. Hotel Shelburne will be the headquarters for the board. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the hotel.

Candidates for re-examination in Part II must make written application to the Secretary's Office not later than April 15, 1945.

The Office of the Surgeon-General (U. S. Army) has issued instructions that men in Service, eligible for board examinations, be encouraged to apply and that they may request orders to Detached Duty for the purpose of taking these examinations whenever possible.

Candidates in military or naval service are requested to keep the Secretary's Office informed of any change in address.

Deferment without time penalty under a waiver of published regulations applying to civilian candidates, will be granted if a candidate in service finds it impossible to proceed with the examinations of the board.

Applications are now being received for the 1946 examinations. For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

Vitamin advertising is under close scrutiny by Federal Trade Commission. A series of recent complaints against excessive health-building claims practically sets down a new code governing such copy. Claims must be limited to specific benefits of a given product—not general statements on nutritional function of vitamin compounds.

National Legislation

H. R. 610 by Mr. Tolan of California. A Bill to Amend Section 40 of the United States Employees' Compensation Act, as Amended, Referred to the Committee on Judiciary.

Comment.—Provides for defining the term "physician" to include chiropractic practitioners; only in those states where chiropractors have been licensed. Further provides that chiropractic practitioners should have hospital facilities such as those enjoyed by physicians and osteopaths.

H. R. 713 by Mr. Dickstein of New York. A Bill for the Creation of Medical Academies Referred to the Committee on Military Affairs.

Comment.—Provides for the creation of one medical academy in each corps area in the United States, each to enroll a minimum of 295 students to be selected as follows: Each Representative and Senator from the area shall designate five principals and ten alternates, any vacancies shall be filled by the Commanding General of the Army Corps; candidates shall be at least twenty and not over twenty-five years of age, shall be graduates of a college or a university or possess the qualifications for entrance into a medical school in the State in which they reside, must be citizens of the United States and of good moral character. Upon satisfactory completion of the course of study the candidates shall be commissioned in the Army, or in the Navy, or in the Public Health Service; they must continue in such service for at least ten years, unless it shall be certified that there is no further need for their services.

WRONGS IN MEDICINE

I have found doctors and nurses so disillusioned by wrongs they see in medicine that they are coming to welcome socialized medicine, even though they know it means that communal system will cause the end of all except the purest scientific ambition in medicine; that doctors will have to become politicians to get ahead in their profession and seek salaries and appointments through the political mill in Washington to the destruction of the best ideals of their profession, and to the worst interests of the common man, the patient.—PAUL MALLON. Feb. 26.

American Medicine has not risen to supremacy because American physicians are supermen, but because they are "free men with fearless minds" and not the slaves of politicians and bureaucrats whose laws and regulations are so difficult to amend, for better or for worse, that they stifle scientific investigation and arrest progress.



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THE MENOPAUSE, a normal event in a woman's life, is for some troublesome and stormy.

For sixteen years Amniotin, a natural estrogen, has been bringing comfort and relief to harried women. Vasomotor and accompanying disagreeable symptoms are lessened, the

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SQUIBB

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

APRIL, 1945

Say you saw it in the Journal of the Michigan State Medical Society

It's The Law, Doctor!

Juris ignorantia est, cum jus nostrum ignoramus—OLD MAXIM

Notes on Court Decisions, Statutes and Other Authorities

J. JOSEPH HERBERT, LL.B., General Counsel, MSMS

Manistique, Michigan

Foreword

Introduction of this column is not intended to supply a refresher course in medical jurisprudence, which, in a strict sense, is the science applying the principles and practice of medicine to the settlement of doubtful questions arising in courts of law. Rather, its purpose is to bring to the attention of the medical profession the expression in current statutory and judicial law of the rights and duties of the physician in relation to his fellow practitioner, his patient, his government, and society as a whole. By means of illustrative cases and comments thereon, and without undue emphasis on legal niceties, it is hoped that the column may contribute to a clearer understanding of these important relationships existing and changing within the complex structure of modern society.

Right of Privacy—Publication of Medical X-Rays, Photographs or Motion Pictures as Invasion of Right

The right of privacy as an independent legal concept is relatively new to Anglo-American law. Although the right "to be let alone" has its roots in ancient common law, and while our courts have recognized it under the guise of property rights, rights of contract and the like, yet it is only within the past fifty years that the distinctive principles on which the right is based have been defined and the right itself formulated.

Interestingly enough, the Supreme Court of Michigan as early as 1881, antedating by several years the synthesis of this new right, allowed recovery in a case wherein a physician took a layman with him to attend a confinement and thus "intruded upon the privacy of the plaintiff." *DeMay v. Roberts*, 46 Mich. 160.

Since the establishment of the right of privacy as an independent concept, two states, New York and Utah, have passed laws protecting this right specifically and many other states have by judicial law given it recognition as a new and independent right. Only in Rhode Island has a court of last resort held flatly that the right of privacy has no legal standing.

Does the publication of medical x-rays, photographs or motion pictures without the consent of the patient invade this new right? Several courts have answered the question in the affirmative.

A federal court in the District of Columbia held that the unauthorized publication of an x-ray photograph showing a foreign article in the abdomen of a woman is an invasion of her right of privacy. *Banks v. King Features Syndicate*, 30 F. Supp. 352.

In Pennsylvania the following case arose. The plaintiff's private physician, having treated her at a hospital, without permission took her picture while she was in a semi-conscious condition, showing facial disfiguration resulting from her illness. His purported purpose was to establish a medical record. The Court enjoined the physician from developing the films and from using the same in any manner, on the ground that the plaintiff's right of privacy had been invaded. The Court said: "Plaintiff's picture was taken without her authority or consent. Her right to decide whether her facial characteristics should be recorded for another's benefit or by reason of another's capriciousness has been violated." *Clayman v. Bernstein*, 38 Pa. D & C, 543.

In New York, physicians took photographs of their patient and published the same, without the patient's consent, as part of an article written by them. It was held that, inasmuch as the article and photographs might be construed as a means of advertising the physicians and their handiwork, a cause of action arose in favor of the patient on the ground that they constituted an invasion of the right of privacy. *Griffin v. Medical Society*, 11 N.Y.S. (2d) 109.

In a published opinion the Attorney General of New York held that the state department of health may not use photographs of persons afflicted with cancer for public display in an exhibit intended for educational purposes at a state fair without the written consent of the subject and without altering the pictures so as to make them unidentifiable. *Ops. Atty. Gen. of N. Y.* (1934) p. 374.

The exhibition of a motion picture called "Birth," showing the performance of a Caesarean section on the plaintiff, entitled her to recover damages on the ground that it violated the New York privacy statute. *Feeney v. Young*, 181 N.Y.S. 481.

In Michigan since 1899 no case has reached the Supreme Court involving a similar question, although as late as in 1917 the court recognized jurisdiction to afford a remedy for the wrongful invasion of privacy. Should a case of unauthorized publication of medical pictures reach our court, no definite prognosis can be made as to how that tribunal would resolve the conflict between the individual's right to privacy as against the public interest which may be served by certain disclosures. In any event, the implications arising from the development and protection of the right of privacy suggests the wise precaution of obtaining the consent of the patient before publishing photographs of his body.

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Michigan Medical Service

UAW-CIO HOSPITALIZATION COMMITTEE REPORT

The Hospitalization Committee of UAW-CIO made a report to the International Executive Board Members on January 21, 1945, which was quite extensive, showing an understanding survey, and containing some pertinent facts that the doctors of Michigan might well ponder, especially in relation to the survey made by Mr. Hunt and reported in this JOURNAL.

"This Committee's first duty to the rank and file is to inform the International Executive Board members that we Michigan Auto Workers are now enrolled in the best Hospital and Medical Insurance to be found anywhere in these United States. Where other than the Blue Cross hospital plans could we get a daily room service valued at about \$7.00 plus extras average value of which is about \$70.00 per hospital stay?"

There follows a page and a half listing liberalizations of both hospital and medical services to take effect April 1.

"This full family hospital and surgical coverage our Auto Worker Families are carrying with the local non-profit plans is by far the most important protection we have and must in consequence get first consideration when insurance topics are under discussion by union people.

"We must, therefore, continue our affiliation with our local nonprofit plans because, first, Michigan Hospital Service is the finest type of service plan it is possible to devise (except for the matter of labor representation).

"Michigan Medical Service writes the most liberal contract we have ever seen and fully protects women, who are two and one-half times the surgical risk men are, plus the fact that they actually pay 90 per cent of the premium dollar back in benefits."

The report discusses sick and death benefits where the Chrysler employee pays \$3.38 for a \$3,000 death benefit and \$21.00 a week for twenty-six weeks' sick benefit. His MHS and MMS cost \$4.00 per month for the whole family. This altogether averages less than 3 per cent of earnings, "which insures Michigan Auto Workers adequately."

"And whether or not the employer can be persuaded to pay this cost, the premium money *must be applied to buying the best coverage available in the locality in which it is needed.* (Italics ours.—EDITOR.)

"The only complaint we have against Michigan Hospital Service is that this organization does not provide adequate labor representation in its executive structure. A complaint that is equally applicable to Michigan Medical Service." It is suggested that the enabling acts be amended to allow "adequate subscriber representation. . . . Since we now have a number of UAW state representatives, we should encounter little difficulty in getting these amendments introduced in the State Legislature. . . . The only other great objection to Michigan Medical Service is the \$2,500 combined family income clause which prevents almost all of our people from getting surgical service without extra cost. Under this clause, the doctors can and are making the gross charge for surgery so high that the surgical benefit paid by the Michigan Medical Service only amounts to half of the gross bill and in some cases less than half.*

*We would challenge the accuracy of this statement. There are probably many cases of extra charges, but probably not to the extent of doubling the whole benefit.

This in spite of the fact that *the surgical rates paid by Michigan Medical Service are as a whole higher than the rates paid by any insurance company.*"

"The Committee offers the only possible solution to this overcharge abuse. Our International Officers should join ranks with other large labor organizations and bring this deplorable condition to the attention of the Federal Government.

"Costs for hospital service have increased over 50 per cent since 1941. Costs for medical, surgical and dental service have increased over 100 per cent since 1941. A few get-rich-quick M.D.'s, osteopaths and dentists have increased their rates up to 300 per cent. *We must immediately ask the Federal Government to place a ceiling on all charges for medical, surgical, hospital and dental service.*

"Certainly we cannot expect the Michigan doctors to voluntarily curtail their earnings by removing the income clause from the service plan certificate at a time when all the other doctors all over the country are enjoying unrestricted privileges.

"We know that had the grocer, butcher and baker been asked to voluntarily place a ceiling on commodity prices, they would never have done so, and the doctors of Michigan are no different. It took the government to do the job, and by the same token, this social evil can be speedily remedied by government action.

"This abuse is widespread and a satisfactory correction cannot be effected by Michigan Medical Service alone. If the issue were forced the doctors would in all probability leave the plan. Nor should the correction of this abuse be restricted to the people enrolled in Michigan Medical Service or . . . only to insured people. These exorbitant charges by doctors are social abuses affecting all the people who in almost all instances are handicapped by the wage 'Freeze.' In consequence a ceiling on charges for these services would help all the people.

"The suggestion that we can overcome (these shortcomings and abuses) by organizing our own Union Plan is simply a misrepresentation of fact, as we would immediately have to look for some cash indemnity insurance to underwrite our Union-operated plan. This could only be cash indemnity insurance and a poor substitute for the splendid protection our Michigan people now get through our local non-profit plans.

"This doctor overcharge beef incidentally ushered in all the recent outbursts of insurance scheming within our unions. However, no plan our union could devise could persuade or compel the five thousand doctors in Michigan to accept insurance benefit rates as full payment for services rendered, nor . . . compel hospitals to accept their daily room benefits as full payment. . . .

"It is highly problematic as to whether our union could operate an insurance plan on a 10 per cent operational cost. . . . We fear it would not be long before our operational cost would mount to the usual 35 per cent. . . . We would be lucky to have 50 per cent of the premium dollar left to pay benefits with, and the only way such a plan could live would be to write poor coverage. . . .

"Under a complete Parcel Blanket system, a system where everyone is insured by the same company for every type of insurance our UAW members stand to lose much and gain nothing, because we cannot avail ourselves of good nonprofit service plans since these are not to be had in all localities."

The report then discusses charges and monthly coverage showing that the Michigan service plans offer

(Continued on Page 391)

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Will Free Enterprise Survive in Medicine?

What the Profession Must Do to Obviate Government Control

By John F. Hunt

Chicago, Illinois



■ WE do not profess to be deep students either of social economics or of the particular problem which confronts the medical profession both locally and nationally. However, as most of you know, we have made two state-wide studies of public opinion in California and in Michigan on the subject of medicine and hospitalization. These studies did a thorough job of establishing public attitude on health and the health professions. You can't dive in quite that deeply without a lot of additional splashing around. As a consequence we have done a considerable amount of additional reading, talking, and thinking on this subject of medical care and how it can best be administered to all people. We feel that we have enough information to have formed our opinions intelli-

gently and to correctly assay the many opinions of others on this subject.

Since we first became actively interested, the problem has attracted far wider attention, and in our opinion is fast peaking up to the point where the pot threatens to boil over. As it stands now it threatens to boil over *on the medical profession*. There is also a third degree burn in store for industry, but at base this is more intimately a problem of your profession. In some sections of the nation the medical and hospital people have become sufficiently exorcised to do a great amount of serious thinking about the best possible way of combating the threat to your profession. However, as yet we have seen practically nothing but conversation or defensive belligerent things in print when quite evidently there is a crying need for constructive aggressive action.

Let us sum up very simply the situation as it now exists. On the negative side these facts are evident to anyone who can read:

1. The attitude of the Federal Government, if anything, is stronger now for Federal control of the nation's health, and consequently the control of the medical and hospital professions, than it was when the Murray-Wagner-Dingell Bill was introduced.

The New Deal pre-election platform declared for a comprehensive extension of the Social Security Act to include a complete health program for everyone in these total United States. Since the election this health program has been included either directly or inferentially in every White House statement on the subject of Social Security.

2. The United States Public Health Service in the person of Dr. Thomas Parran, its head, flatly favors a national health program based

Address before the Annual County Secretaries' Conference, Michigan State Medical Society, Detroit, January 28, 1945.

on government control. Just a week ago in this city Doctor Parran listed for his United Automobile Workers' audience the steps which he believes should be adopted in the government's health program for the nation. You are as familiar with them as I, so it's not necessary to detail them here.

I shall not attempt to raise your blood pressure by citing all the other manifestations of government intent as far as national health is concerned. I know full well that practically all of these indigestion items have come to your attention. I know equally well that despite the fact that some modifications are being considered for the Murray-Wagner-Dingell Bill, you must have appraised the situation as becoming additionally alarming as far as your professional ambitions are concerned.

3. The attitude of the government is not the only thing that must have concerned you. You know as well as I the temper of the government crusaders for total Social Security. I believe that you will agree with me that they will need no urging, no prodding to take both medicine and hospitalization under their wing as soon as they possibly can. But if they should be at all dilatory about it, I would like to remind you of a very potent pressure group who will flog them into action if any whipping is necessary. I refer, of course, to the pressure which has been building up for the last twenty years through organized labor. In that period you know as well as I do that the labor movement has made terrific strides in numbers, organization and in a realistic perception of its power in forcing acceptance of its demands.

At one of the meetings of the national convention of the American Hospital Association which I attended in Cleveland last October, a representative of the United Automobile Workers, Mr. Clayton W. Fountain, flatly tossed into your lap an ultimatum from the CIO. You can be sure that Mr. Fountain was also speaking for the AF of L. He said, and I quote him exactly:

"I say that labor supports the Murray-Wagner-Dingell Bill because private agencies in the medical field are not doing a proper and adequate job of insuring the health of the common people of America. It is strictly a practical problem with us. You will not change our minds on this issue by talking in terms of socialized medicine, bureaucracy, regimentation and all the other nonsense with which this controversy has been cluttered up. . . . Joe Worker wants health and he is

going to get it one way or another. He knows that modern medical science can provide him with health. So if those whose business it is to keep him healthy do not do the job to his satisfaction, he is going to turn to the state for help. . . . Until Medicine itself offers Joe Worker more health security at lower prices than the government can submit, we are going to stand pat on our support of the Murray-Wagner-Dingell Bill."

There, in a nutshell, is labor's ultimatum to the medical and the hospital professions. . . .

And if there is anyone in your profession who still is of the opinion that labor speaks in a small voice, I would like to give you just a couple of figures. Fairly accurate sources give the CIO between five and six million members. The same sources estimate the AF of L membership between six and seven million. If you take the low figure in each case you have a total of 11 million individual labor votes. I doubt if there is anyone naïve enough to even hope that each labor member would not vote his complete family as a unit on a question of this kind. But to be conservative, let's just say that each labor membership represents only two family votes. You have then a total of 22 million individuals who have told you in unmistakable terms that they are in favor of government-controlled medicine and hospitalization *if you don't provide them* with the kind of health security which they demand.

In order to more simply indicate the strength of this pressure, let me remind you that in the last election there were approximately 49 million votes cast. Twenty-six million of these returned the New Deal to the White House. Need I remind you that the proponents of the New Deal have a pretty good record of getting the things they want and go after?

If those two major and formidable threats to the private control of medicine are not sufficient to spur your profession into an immediate campaign of action far better planned and more aggressive than I have seen so far, I would like to drag out another red flag—the *imminence of state action* if the federal government *doesn't act* soon enough. You know what is happening in California. . . . You are currently embroiled in trying to stop inimical action in this your own state of Michigan. The State of New York some months ago created the New York State Temporary Commission on Medical Care. Immediately after Governor Dewey appointed this commission I was given to understand from a reliable source that his instructions to the new commis-

sion were to put together a state health program which, if anything, would be more far reaching than the pattern proposed by the Murray-Wagner-Dingell Bill.

Other states have attempted to institute a state control of medicine and have failed. Perhaps you would have been less than human if you had not hugged these failures to your chests—if you were not now using them as a pillow on which to rest your uneasy heads. But I am sure that *in your net thinking moments* you are no more naïve about these failures than am I. This kind of gospel, whether it be unsuccessful for the moment or not, is the evangelistic kind that is easily preached—and pretty easy to accept for the majority of our people.

From all of the above you might possibly gather that I am unalterably opposed to the extension of complete health security under the auspices of the state or of the national government. I am not. I thoroughly believe, as I am sure all of you do, that all of the people of this nation, regardless of race, creed, geography, or income should have total health security. Aside from the humanitarian aspects of such an objective, it must also be remembered that the total health of any nation is one of its most basic wealths. In the past few years we have seen classic proof of this. Certainly the total health of this nation, as illustrated by Selective Service and other government figures, is nothing to be proud of.

It is thoroughly reasonable to conclude that these figures are of graver concern to the medical profession than to any other group of citizens in or out of government. Certainly you as a group in your professional pride and enthusiasm are unquestionably more eager to improve the health of this nation than are those who would accomplish it by fiat. Where you differ and where we differ with your opponents is on the methods under which complete health security is to be brought to the people.

Our interest in this matter stems from our conviction that our own private health and the health of the nation as a whole would be more secure under the extension of medicine as it is now practiced than under a type of medicine dispensed under government control.

Let me repeat, we believe that all people, regardless of their position, are entitled to health security. We also believe that this can be ac-

complished without taking control of medicine out of your hands.

We also, I hope, can add two and two and come out with four for the answer. Elementary reasoning leads us to the conclusion that within a relatively short period of time, either through you or through the government, a comprehensive health plan for the nation as a whole *is going to be instituted*. We are of the firm conviction that you, and only you, can remove the threat of government action. But as the voice of labor and a number of individual voices in your profession have maintained, you cannot do it by merely talking against it. It can be done only by definite, well-planned, constructive action.

A few minutes ago we briefly outlined the forces that are pushing for government action. You have a greater average intelligence on your side. At the present you also have a slight edge as far as the general public is concerned. But there are several essential and very important differences between you and your opponents.

The first of these is—they are united and you are not. The second is—you must first produce health for the nation as a whole—you must bring medical and hospital care to the neglected segments of our population—before you can finally consider the threat of government control a dead issue. Your opponents need only to show that you have failed to give total health coverage to the nation before some day they decree it through the power and under the control of the government. In other words, while time still remains, you have far more to do than have your opponents. You must unite and you must produce.

There are several other basic things that you must do. You must *sell* the advantages of *your type* of health care to the *public*. You must *solicit and win the active support of industry*. The latter is already sympathetic on two scores. First, industry realizes that if the threat to your profession becomes an actuality, industry will be forced to carry a big share of the financial load of the government health program. Secondly, it must be apparent to—at least—the alert people in industry that government control of medicine would be a definite encroachment on Free Enterprise. They realize also—or should—that the regimentation of any single profession or business weakens the whole Free Enterprise structure and jeopardizes all organizations which have flourished under this basic American business formula.

What the Profession Must Do

Your job—the job of each state medical society—in my opinion, naturally divides into two parts: First, what you must do in your own backyard—within the confines of your own state.

The second part of your job is what you should do outside of your state whenever you can possibly be effective in any one of the other 47 states of the Union.

Obviously, one of the first things that should command both your attention and determination in your own state is the union of all medical and associated groups within the state—the adherence of every one individual of these groups to this one common aim—the perfection and extension of state-wide health through all of those means over which you exercise control.

The second basic thing that your profession must do is to thoroughly sell to the total public in each state your accomplishments to date and your plans for perfecting and extending your facilities so that each citizen may confidently look forward to the time—and a not too far distant one—when everyone in each state of the union will be assured of a comprehensive program for health security under your auspices and control.

It should not be necessary to “sell” co-ordination of effort to any individual whose profession or avocation is in any way connected with the health picture. I mean doctors; I mean hospital personnel; I mean all the people of the health service organization; I mean all the pharmaceutical people. All of you and all of them should unite for common action.

You people in Michigan have made great progress—in fact far greater progress on a state-wide basis than I have seen in any one other state in the Union. And yet, I understand, that surprisingly there are *even some doctors* in the State of Michigan who have not as yet evidenced a willingness to endorse and to enthusiastically support and co-operate with the two state-wide functional organizations that you have here, and which you need if a total health objective is to be accomplished. I refer of course to the Michigan Medical Service and the Michigan Hospital Service.

Obviously, you need an implement to effect a state-wide health program covering all people. You cannot possibly do it as individuals. In these two service organizations you have this necessary implement at hand.

Particularly in the Michigan Medical Service, you are far ahead of the rest of the country. If all states had made as much progress as you have made in making available medical as well as hospital coverage on an acceptable economic basis, your prospects of retaining control of medicine nationally would be far more promising. If you really want to demonstrate your already evidenced capacity for leadership, you will win over the remaining apathetics in your profession and you will all as a completely united group, step up your enthusiastic support of these two organizations. You already have adequate proof of their value in helping to solve your overall problem. The survey of public opinion of this state clearly indicates that the activities and accomplishments of these two organizations are in large measure responsible for the more favorable attitude of Michigan people toward voluntary medicine and hospitalization than is the attitude of the nation as a whole.

I say that your attention first should be centered on ultimate organization because the selling job that you have to do will be infinitely easier if you are solidly united.

That you *have* a selling job to do here, as in other states, is immediately evidenced by the fact that there is inimical legislation threatening in this state. If, in the past, you had done a sufficient job of selling your type of medicine to all the people of Michigan, this initial petition would never have gotten as far as the printer.

You are determined that this legislation shall not be enacted. To insure this and also to insure that similar legislation will never have a chance in this or any other state, you and the profession, nationally should be active in extending health care economically to all the people. But don't stop there. You should be concurrently active in convincing the people of Michigan that the complete health of Michigan is safe in your hands.

You are influential people, all of you, in your communities. Because you are, each of you must reflect what you want the public to think about medicine privately practiced. To begin with, each one of the 5,000 doctors in Michigan should take stock of his own sales equipment and of his past effort in selling the people of his community on the ability of the medical and hospital profession to adequately handle the health problems of *all the people* of this state. Each doctor in this state must be sincerely interested in solving

the health problems of the underprivileged people in the whole state of Michigan. Each doctor must also convince the people of his community that not only he but the whole medical profession is concerned about health for *all* the people and that the entire profession is active in supporting organizations to accomplish this end. Providing health security for the low-income and indigent segments of society is the primary reason for either state or national legislation. If you remove the problem, you remove the need for justification for such legislation either locally or nationally.

Each doctor in Michigan—or Maine, or California—should not only become more articulate on voluntary health care with his own patients and among his own circle of friends, but all of them should deliberately seek opportunities to publicly explain the past really great accomplishments and the objectives of your type of medicine.

You doctors should be on friendly terms with every newspaper in your community from the large metropolitan dailies down to the country weeklies. You should fully inform them of the past accomplishments of the medical and hospital professions—not just through your society releases to the press, but through personal contact. You should take them into your confidence about the means you intend to employ to extend adequate medical care to *all* the people of this state.

The job of newspaper people is to find and to print news. There is no better way of acquiring their good will than by co-operating with them in their job. When they come to you or your institutions for a news story, make it easy and pleasant for them to get it. If you do, you'll find them wanting to line up with you or at least willing to listen to your side of the story.

As you make progress in extending medical care to additional numbers of people, let the public know it. There are plenty of ways available to you of keeping the whole public fully informed of the month-by-month progress in attaining your ultimate goal, which I need not remind you, must be complete health care for all the people on a basis which they can all afford to pay.

I said a while ago that you must not only be concerned with the progress and the ultimate fate of medicine within your state, but you must also be interested in doing whatever you can to further the cause of voluntary medicine in all other states in the union.

As I *also* said before, *you in Michigan have*

proved your capacity for leadership through the very progress that you have made within your own state. You should take every means to convince your professional associates in all other states that what has been done in Michigan can also be done in their own states as well. Don't content yourselves with trying to improve what you have at home, but spread the Michigan gospel. It, too, should be easy to preach and far easier to accept by those people who will ultimately have a hand in deciding what kind of medicine we are going to have in this nation.

These suggested activities are necessarily long haul. Given plenty of time, I feel confident that they would have a beneficial effect. But you cannot safely count on having enough time to do the job solely by long haul methods, so before I conclude, I should like to make a suggestion which would make quick action possible. I should like to make it to you because the medical profession in Michigan, by the very virtue of its accomplishments, has one of the best rights to speak, or make a proposal to your associates nationally. My suggestion flows from the fact that, as I said before, your opponents are organized and you are not. Your opponents are talking about a *complete health program*. They offer a comprehensive package, and you do not. Too many people on your side of the fence are thinking and talking about only a *part* of a complete health program. The medical people are thinking principally in terms of medicine.

The hospital people are thinking chiefly in terms of hospital care. If you are to succeed in providing a comprehensive health plan for the whole nation under private instead of government control, you must close this gap by forming a new organization—an organization which will integrate for common action all factors in the whole health picture.

For now, let's call it The National Health Congress.

It should be a congress in every sense of the word. It should be composed of elected or appointed members from each specific activity that has anything to do with the health picture. Its members should include doctors, hospital administrators, service groups, nurses, dentists, representatives of the drug or pharmaceutical business. It should include representatives of industry because industry has its own stake and obligations

in the health of its employes. It should include representatives of labor, because labor, too, has rights. It is more sensible to acknowledge these rights and to work with labor than to invite opposition by failing to let them have a hand in shaping a health plan for *all* the people.

While the purpose of this congress would be to insure complete national health coverage *under private control*, the assistance of the national and state governments in financing health care for the indigent and other public charges would still be necessary. Consequently, it would be advisable to consider offering to the national and to each state government proper representation in the health congress.

Each state in the union should be represented on a basis equitable to each state. The doctors in each state should appoint or elect their members, the hospital people theirs, industry theirs, and so on—more or less as our national legislative bodies are formed.

Since this proposal visions a body created *for action*, each member should be empowered to act by and for those interests represented. Without this delegated power, the desired initial objective—a workable, private control plan for health coverage of everybody in this nation, will not be accomplished, or at least will not result in time to obviate government control of medicine.

You already have your American medical society. The hospital people have their national association. The dentists have theirs, the nurses theirs, and so on. These, of course, need not be displaced, but there should be a national body which would merge objectives and abilities of all health factors into a comprehensive group for concerted action. Never before has there been such a need for united action, if through private means and voluntary methods complete health security is to be brought to all the people of this nation. I am sure that all medical people want that. I am sure that all hospital and other health professions want it. I believe you stand a better chance of accomplishing it, if you pool your abilities and your efforts through a single united body to serve as a front line organization for all interests in the total health question.

≡ MSMS ≡

The Children's Bureau is now dictating how the pregnant wives of soldiers, sailors, and marines and their babies shall be cared for, if they are to receive Federal aid. And that care is inferior to standards set up and being given throughout the nation.

American Medicine in Transition

By Edward F. Stegen

Chicago, Illinois



Associate Administrator National Physicians Committee.

■ I AM sure that you will find nothing new or particularly startling in the few remarks which I shall make this evening. The postulates which I have chosen as the framework of my address are the moral essentials of freedom, human progress and faith in the infinite value of the individual man.

For the purposes of bringing these postulates into some close-drawn application to medicine, I shall bring against them a series of hypotheses. This process, like an oft-proved chemical or mathematical experiment, will reveal within the limits of my rhetorical skill the eternal nature—the substance, the timelessness of these truths.

American democracy is the expression of the moral, intellectual and spiritual will of the people to live under and to share with each and all other individuals the freedom, the individual liberty, and the progress which are guaranteed by our constitutional government. The infinite worth of the individual is such a tower in the scale of human values that he has rights even against the State. That is a moral absolute which has nothing to do with his relative worth, his economic or social potentials—it is spiritual and derives from the Infinity which created Man as the only moral and reasoning being on earth.

In his remarks at the recent National Conference of Professions, Insurance and Industry, Dr. Theodore Klumpp strikingly referred to one of the characters in Ernest Hemingway's novel, "For Whom the Bell Tolls," who speaks of feeling the earth move. In her experience that movement was so vivid it seemed an actual physi-

Address delivered at the Annual Conference of County Secretaries of the Michigan State Medical Society, Detroit, Michigan, January 28, 1945.

cal phenomenon. Less vividly, but with far greater certainty and with vastly more important implications the "earth *has* moved" in our time. Slowly through the centuries the fight for individual freedom was won—it was, to use a currently expressive term, an "island-hopping campaign." Every beachhead has been a bloody chaos over which the spirits of men have driven to the possession of a new island of truth in the turbulent seas of ignorance and fear.

In our time we have seen a retreat of the spirit. We have seen humanity lose much. We have witnessed a return of barbarism. We have seen the golden thread which binds man to God come perilously near breaking under the strain of an evil weight—the weight of moral disintegration. The ascending curve of man's progress has temporarily turned sharply downward. Fear and moral confusion are the factors which have bent this heaven-bound curve toward the gaping hell of defeatism.

In every period of moral stress the individual loses. His rights are usurped by the state. His identity as the "Image of God" is taken from him. His spirit is shackled with laws, his mind is fenced in by dictum and directive and his body survives only because it has the vitality to bear the heavy knapsack of prohibitions which the state has laid upon it.

When the state has had such an ascendancy of power the exercise of that power becomes an end in itself. Moral restraints are erased. Expediency, defined in the terms of a collectivist ideology, becomes the *modus operandi* of government. Truth and falsehood are used interchangeably to deceive. Promises are made to be broken. Charters are written to be repudiated. Negotiations between nations are the cloak for treacherous assault.

Once men accept the falsehood that there is no absolute except power—that fixed ethical standards have become only relative, Hitlerism has been justified and Hirohito has truly earned and justly possesses the deification which the Japanese have traditionally ascribed to the Mikado.

In America our recently developed defeatist attitudes toward the great moral imperatives is a reflection of weakness in the struggle for freedom. The classic, though ungrammatical question which editorial writers and lecturers have asked most frequently during World War II is, "What

are we fighting for?" and then they have strung the pearls of their own wisdom in an effort to build our patriotism to more heroic proportions. Actually our brave sons and daughters of the war fronts are fighting for the freedom of the individual, fighting to re-establish for all time the absolute value of the individual human being. This war is complicated by bigness, by individual and national motivations that have only partially emerged—but stripped of confusion, which is the hand-maiden of war, we are fighting that all men may have the fullest realization possible of the "Image of God."

We on the home front have not been excused from our share in this great war of ideologies. As the keepers of the Grail we owe to our warriors the stewardship of faith. It is our task to preserve the cherished institutions of democracy—the vessels in which all the attainments, the victories, the honors and the hopes of freedom are stored. May God give us the courage, the wisdom and the strength to keep the stewardship of faith. There must be no moral collapse here at home.

Democracy, I repeat, is based upon a moral absolute. Once that absolute is compromised into relativity, it disappears entirely. That strong movements toward this kind of defeatism are in the minds and hearts of American men and women today is evidenced by the new terms in which our national aims are described, the new and often charming names that have been given to the objectives of the social state. In return for our souls we are to receive benefits, care, security, freedom from want, freedom from fear, freedom from all of the hazards of life, parities, subsidies, surplus marketing, bonuses, grants, indemnities, support payments, and with the lavishness of a true spendthrift the state will crown the whole abundance of its gifts with freedom of speech and freedom of worship. To appeal from such a bountiful shower of good, marks one as an ingrate, a reactionary, and a little farther down this trail of collectivism your name changes to revolutionist, anarchist or traitor. And should you be so bold as to inquire from whence comes the power, the funds, the authority, the license and the rules by which the state will perform its miracles of grace and substance, you are marked in some circles as a bloodless capitalist inspired only by your own greed and impelled in the inanity of your questioning by a so-called old-

fashioned notion that "all men are created equal; that they are endowed by their Creator with certain inalienable rights; that among these are life, liberty and the pursuit of happiness."

Lest my remarks be misinterpreted to be a specific charge against our present national administration, I hasten to point out that the *race* toward statism is not the exclusive and special interest of the New Deal, of the Democrats, the Republicans or any other political party, or segment of a party. We have been in the race for more than a generation, and if our pace is accelerated now, that phenomenon is as much due to a tail wind generated by world events as it is to our present coaching in Washington.

What can be done to slow down this accelerated pace is the greatest and gravest problem which each American faces today—because in the fast race toward statism lies the kind of moral defeat that may well liquidate the victory which all of us hope and believe will soon come to our fighting forces around the world. In many ways the social science doctors who thrive on the sicknesses of the distressed community or nation have blinded us to the real considerations and the fundamental questions involved. The collectivist economists and social planners riding on the band wagon of government have left no stone unturned to convince us that we, although creatures endowed by God with inalienable rights and abilities, cannot get along without a governmental hypodermic needle pumping stamina into our veins.

It is too much, perhaps, to hope that the national leadership which gained power out of our depression-born defeatism can change its methodology even under the duress of war. It is too much to expect, no doubt, that politicians who have won the longest periods in office in all our history by the irresponsible use of the hypodermic needle will suddenly change from a counsel of despair to one of dynamics and confidence.

As long as we are dominated by the defeatism which demands the aid of government witch doctors—the constant injection into the veins of our society of hastily-brewed economic, social and political serums of unknown or questionable potency and efficiency, we will never stand on our feet as real Americans and carry individually the proper portion of community responsibility which should be ours. As long as we, the people, go to Washington for our every need, as long

as we permit the use of that great synthetic "government action" as a substitute for individual responsibility and courageous individual attack upon our problems, we will never free ourselves from the enervating and devastating effects of the trend toward collectivism.

I have indulged your patience thus far without pointedly bringing any close-drawn application to medicine. However, I have taken these liberties because I believe that it is necessary to move back a considerable distance from some things in order to examine them in their true proportions. I sincerely hope I have not erred by going too far back like the young soldier who became so frightened on his first day at the front that he dropped his gun and headed for the rear as fast as his legs could carry him. He ran until he was almost exhausted when a soldier halted him with the sharp question—"Why didn't you salute me?" "Who are you?" came the panting response from the fast retreating soldier. "I'm a Colonel of the First Army," snapped his superior. "My Lord," said our soldier boy, "Have I run that far back."

Moving up then to a consideration of the relative place of medicine in the fight to preserve for this nation the great traditions of freedom—the defense of the moral imperatives of the American way of life, I propose to show you that the learned profession of medicine, through its unity of purpose and with a continuation of consecrated and intelligent leadership, can lead America away from the false security of cowardice and upward and onward to new adventures of freedom.

In the United States we have never witnessed a transfer of function from the field of purely individual activity to that of government activity. As pointed out by Dr. Herbert D. Simpson, economics counsel of the National Physicians Committee, in an address at a recent national conference, there has always been an intervening stage, a period in which the problem hangs in suspension and during which public opinion makes up its mind one way or the other. This is the stage in which certain activities are institutionalized. It is generally agreed that the *distribution* of medical care is now in this period of suspension. Public opinion is fluent on the subject—it *will swing to a crystallized position within the next two years and at this moment it is impossible to predict whether it will swing to state medicine or an*

institutionalism under the traditional concepts of free enterprise. However, I wish to emphasize by repetition that *our great profession can swing public opinion to a positive position which will make it impossible for the collectivists to steal from our people their birthright of freedom,* not only in the field of medical care, but, more importantly, will start this nation on the road back to spiritual, social, economic and political good health.

Perhaps some of you find it difficult to believe that American medicine must add to its task of caring for the ill and stricken, the challenging responsibility of social and economic leadership in the distribution of medical care and services, but this is "the call" of our time.

It is generally believed that the *distribution* of medical care, as distinguished from medical care itself, will be institutionalized. This fact stands out in the results of every survey of public opinion which has been made on the subject. *The American people are demanding some provisions against the hazards of illness and disability.* Particularly, *a majority of our citizens want economic protection against catastrophic and extended illness.* This public demand means that we no longer have a choice in the distribution of medical care between purely individual activity and governmental activity. That choice has vanished. *Your choice, the choice which the American people will be in the process of making during the next few years, is a choice between two types of institutional responsibility—private or public.* If medicine will rise to the challenge of leadership, thoughtful and courageous men and women all over America will stand with you against the intrusion of the killing hand of bureaucracy into the field of medical care, and not all the cascades of beautiful words about new social goals, bold social engineering, or the tongue-in-cheek promises of security from the cradle to the grave will prevail against us.

Fortunately for the American people the medical profession has a constructive and specific program that in all respects protects the interests and the dignity of the individual, insures the creation and the extension of voluntary plans of health insurance. That program is expressed in a recent statement of policy of the Michigan Physicians Committee. Its significant phases are:

"To encourage individual physicians and medical societies to active participation in the development of plans and more general use of existing facilities to provide for easy payment of insurance against unusual and prolonged illness.

"To educate the people to the importance, nature and value of prepayment facilities now available.

"To provide authoritative information for business and industry concerning the principles underlying sound participation with employes in group health and disability insurance.

"To offer to the sponsors of voluntary nonprofit insurance plans and to commercial insurance underwriters information and technical assistance for increasing participation and otherwise extending the usefulness of group and individual contracts.

"To give substantial encouragement to state and local governments to provide financial aid for the effective medical care of the indigent."

The participation of physicians throughout the length and breadth of America in this constructive program will do more for the preservation of the free and independent practice of medicine, for the more effective distribution of medical care and medical facilities than any other single force. *Today American medicine's greatest danger lies in the possibility that it may fail to meet the challenge of protecting those fundamental concepts which have been the guiding stars of progress in the past* and which today, tomorrow and forever are the celestial lights by which man must chart his course toward freedom. The leadership of your learned profession in the struggle for human progress, for the protection of the dignity and sanctity of the individual may very well be the benchmark from which we as a nation will measure a new era of freedom, a greater exercise of our rights of citizenship and a renewed faith in the moral absolutes of democracy.

In conclusion it is particularly apropos to this occasion and to these days of struggle that I should quote the lines of your own gifted colleague, Dr. Spencer Free:

The world wants men, large-hearted manly men;
Men who shall join its chorus and prolong
The psalm of labor and the psalm of love,
The times want scholars—scholars who shall shape
The doubtful destinies of dubious years.
And land the ark that bears our country's good
Safe on some peaceful Ararat at last.
The age wants heroes—heroes who shall dare
To struggle in the solid ranks of truth;
To clutch the monster error by the throat;
To bear opinion to a loftier seat;
To blot the era of oppression out,
And lead a universal freedom in.

The Council on Medical Service and Public Relations, A.M.A.

The Work of the Washington Office

By Joseph S. Lawrence, M.D.
Washington, D. C.



*Director Washington Office,
Council on Medical Service
and Public Relations A.M.A.*

■ THE program of the Washington office is intended to be a two-way activity. You, the representatives of the State societies, are asked to report to us the attitude of your congressman upon matters relating to medical service. You will keep us informed of any expression or other evidence you may have as to whether your congressman is for or against state medicine or other bills pending before Congress. In return, we shall report to you the bills relating to medical service as they are introduced, their sponsors, the committees to which they are referred and other information which we may have regarding them. We shall also report to you actions of your congressman with regard to pending legislation. If he makes an address before Congress, or if he is a member of a committee to which a bill has been referred, we shall so advise you. We shall also advise you of reports that may be submitted by government bureaus on matters relating to public health and medical service.

The effectiveness of this program will largely depend upon our mutual interest and co-operation. When we report matters as before Congress and suggest that you take these under discussion with your legislators, we also suggest that you discuss them with leaders of your com-

munity, other than doctors, and ask that they, too, correspond with the congressmen.

A congressman's position upon proposed legislation is intended by him to be a reflection of the opinion of people in his district. He will not very often voluntarily oppose his own opinion to that of the people of his community. It is only fair that you should make an effort to have him understand what the feeling at home is and this can best be done when you survey it yourself, with the assistance of public leaders outside of the profession.

I should like at this time to suggest that the County societies make a special effort to understand what the feeling of the community is with regard to the medical situation . . . this can best be done probably by inviting public leaders, both lay and official, to come before the County society at intervals and discuss the situation as it appears to them. In this instance, the little expression from Robert Burns might be put in this way, "To see ourselves as ithers see us and also to help ithers see us as we see ourselves." Probably we very frequently discuss among ourselves in the County societies measures that have a public interest, but the benefit of our discussions is not appreciated by the leaders of the community because we have not taken them into our confidence. Here I feel we are missing a most excellent opportunity of developing such programs as we, from our experience, know the community needs. True public relations must, of course, include the public and can't be limited to our own discussion among ourselves and our own profession. Our work with our congressmen should be in the nature of public relations.

May I repeat again that it is most essential that we establish with our immediate congressman a relationship that will permit us to tell him our feelings with regard to legislation that is pending . . . not necessarily asking him to vote as we would vote but rather giving him the benefit of our opinion as to the merits of the legislation and letting him then make his own decision as to how he should vote. Of course, we must remember that there are other groups in the community and some of them may differ with us in opinion as to the merits of legislation and the congressman, naturally, must decide for himself whom to support before he casts his ballot.

Address given at the Annual County Secretaries' Conference, Michigan State Medical Society, Detroit, Michigan, January 28, 1945.

The Vocational Rehabilitation Program of the Federal Government

By E. F. Sladek, M.D.
Traverse City, Michigan



*Chairman of the Council,
Michigan State Medical Society.*

■ VOCATIONAL Rehabilitation is a service to conserve the greatest of all assets—the working usefulness of human beings. It is a public service for the disabled civilian, comparable to public education, public health, and other activities for the welfare of the people. By means of this plan the United States Government is embarking on a social program which seeks to aid the disabled individual in the solution of his particular problem through the purchase of professional health services. The Government, having first determined just what the disability is, offers professional advice and guidance, purchases medical and surgical services for the correction of the disability, trains this individual in some occupation in which his disability does not handicap him, and finally places him in industry so that he becomes self-sustaining and self-sufficient.

Development of Vocational Rehabilitation

This social program is a direct result of the First World War. At the end of the war many servicemen returned with disabilities which prevented their re-entering former occupations. The United States Government recognized its responsibility to these men and in 1918, Congress passed an act to provide for their retraining for employment. Because of the success of the program the Federal Government has encouraged the states to participate in extending the benefits of vocational rehabilitation to *any* adult having a disability which is a vocational handicap. The program is *not* limited to veterans.

Presented at the Annual County Secretaries' Conference of the Michigan State Medical Society, Detroit, January 28, 1945.

Michigan was one of the first states to co-operate and passed its Rehabilitation Acceptance Act on May 17, 1921. Under the State Board of Control for Vocational Education, thousands of persons have been rehabilitated in Michigan and have become self-sustaining instead of remaining on relief rolls. Up to this time services only were given to physically handicapped persons, who by reason of their handicap were unemployed and unable to earn a living. Economic need was the only criteria for rendering services.

The Congress, in July, 1943, enacted a series of amendments to the Vocational Rehabilitation Act in Public Law 113. This law greatly expanded the types of services, broadened the eligibility for services, particularly emphasized physical restoration, and removed the fixed ceiling on the use of Federal funds for the program. *A direct result of the law is a definite increase in Federal control over the States' programs.* Each state must submit to the Administrator of Vocational Rehabilitation, Federal Security Agency, a detailed plan of operation for approval. These plans must follow specific regulations, requirements, and recommendations of the Federal Government.

Services Provided by the Program

The rehabilitation of an individual consists of a number of factors, part or all of which may be required for successful adjustment. These are: (1) location of the disabled individual; (2) medical examination, diagnosis, and prognosis; (3) vocational counseling, training, and placement; (4) physical restoration, including medical and surgical treatment, physical, occupational, and psychiatric therapy, and the furnishing of artificial appliances; (5) financial assistance to provide maintenance, transportation, and occupational tools and supplies during training and in industry.

Physical examination, vocational counseling, training and placement are supplied at no cost to the disabled, *irrespective of economic need.* All other services are provided at no cost where a well-established economic need exists, except for war disabled civilians and civil employes of the United States injured in the line of duty, who are given these services irrespective of financial status.

All services supplied are purchased from exist-

ing and established public and private facilities. No special works projects will be established. Instead, training is obtained from public and private schools, vocational training courses, and from in-service training on the job. No new medical centers or hospitals are established. Medical and surgical diagnostic services and treatment are purchased or secured from practicing physicians. Hospital care is purchased from existing public and private hospitals. Employment is secured in private business and in Government on the customary business basis.

Eligibility Requirements

The plan in operation in Michigan during the past twenty-three years supplied services to any handicapped individual who by reason of his disability was unable to work and sustain himself. The major source of case-finding came from the offices of public employment, public assistance, and public welfare.

Under the new Federal law and regulations, mental illness and blindness, as well as physical handicaps are included in the services available. Likewise, eligibility for services is expanded to include three main groups: (1) disabled individuals; (2) war disabled civilians (3) Civil employees of the United States.

A disabled individual is one, who by reason of his disability, is unable to work and to sustain himself.

The term "war disabled civilian" is defined as any civilian disabled while serving, at any time after December 6, 1941 and prior to the termination of the present war, in (1) the Aircraft Warning Service; (2) as a member of the Civil Air Patrol; (3) as a member of the Office of Civil Defense or the Civilian Defense Corps; (4) as a registered trainee in any of the civilian protective services; and (5) as an officer or member of the crew of a vessel owned or chartered by the Maritime Commission or the War Shipping Administration. No individual shall be considered a war-disabled civilian unless he is disabled as a result of disease or injury incurred in the line of duty during this period, and not due to his own misconduct.

A civil employe of the United States is one who is not covered by civil service regulations nor by the U. S. Employees' Compensation Commission; for example, an employe of the OPA.

The World War II veteran will be entitled to

vocational rehabilitation services under this Law, but undoubtedly, their medical and surgical care will be given by the Veterans Administration in their own facilities, manned by full-time physicians.

Administrative Personnel

As physicians, we are particularly interested in two objectives sought by the program:—the original medical diagnosis, and the physical restoration services.

Under the combined direction of the State Board of Control for Vocational Education and the State Welfare Department administering the program for the blind, the organizational structure of the administrative unit of the State plan consists of:—the Supervisor of Physical Restoration; a Medical Administrative Consultant; and—a Medical Social Work Consultant. The duties of any two of these officials may be combined under one person. Technical advice may be supplied by the Medical Advisory Committee, consisting of representatives from all allied professions of medicine. This committee is appointed by the Director of Rehabilitation, State Board of Control for Vocational Education. In addition, the Council of the Michigan State Medical Society appointed a Special Medical Advisory Committee on Physical Rehabilitation which was instructed to aid the State Board of Control in the formation of policies and procedures, particularly regarding medical care.

Up to now, only one administrative office is filled. Miss Katharine Post, the Medical Social Work Consultant, is doing a superb job in performing the duties of all three offices. She is confronted with the herculean task of setting up the new state plan for the agency. Miss Post constantly seeks and accepts advice from members of the Physical Restoration Committee of the Michigan State Medical Society. It is her hope, as it is the recommendation of the MSMS committee, that a doctor of medicine can be employed by the state agency to act in the dual capacity of Supervisor of Physical Restoration and as the Medical Consultant.

Standards for Medical Personnel Providing Services

The Federal Agency insists that the best medical care available be purchased. It sets up high standards for these services. Medical diagnosis

and treatment of disabled persons shall be limited to physicians licensed to practice medicine and surgery and otherwise qualified by training and experience to perform the specific services required. Services of specialists are to be utilized when necessary and available. The State Agency determines which of the services required by an individual should be rendered by a specialist. Where certified specialists are not available, those physicians who have the training and experience qualifications for admission to examination by specialty boards and those qualified by practice in specialty fields can be used. The Medical Advisory Committee must grant specific approval in each instance.

Individuals with any type of visual handicap are to be referred to qualified ophthalmologists for examination and treatment. Those with minor visual handicaps, who in the opinion of the examining physician, require only refraction, may be referred to physicians with special experience in Eye, Ear, Nose, and Throat work or to optometrists. The Federal agency strongly recommends that well-organized clinics offering combined services of qualified physicians of differing skills be utilized wherever available for diagnosis and treatment.

Emphasis is placed upon free choice of physician by the client in procuring the services he requires.

Corrective care is given only to "static" conditions; conditions which constitute a substantial handicap to employment and yet are of such a nature that corrective surgery or therapeutic treatment may reasonably be expected to eliminate or arrest and substantially reduce such handicap within a reasonable length of time.

Medical Diagnosis

Every disabled person making application for rehabilitation services must first have a complete physical examination. In Michigan, he is referred to his family physician for this purpose. This preliminary medical diagnosis involves:

1. A general and complete survey of the physical and mental make-up of the individual.
2. The discovery of the handicap which makes the individual unemployable.
3. Evaluation of the physical or mental handicap as to whether it is "static" and not acute or chronic.

4. Prognosis as to the future course and effects of the handicap, and as to whether its correction will enable the individual to accept self-sustaining employment.

5. Recommendations as to:

- (a) additional laboratory and x-ray diagnostic procedures.
- (b) hospitalization to arrive at a diagnosis, (up to three days with an additional seven days on special approval).
- (c) referral of the client for specialist services, either diagnostic or corrective.
- (d) the means and methods of the corrective procedure which is to remove the obstacle to employment.

This requires more than an ordinary physical examination. It involves a keen perception of the problem of the physically handicapped. The report of the examining physician may be the main factor in determining the type of rehabilitation program for that individual, and it is important that these reports be full and complete.

Medical and Hospital Services

The regulations covering physical restoration make provisions for professional services consisting of home calls; office treatments; medical and surgical care in the hospital; convalescent care in the hospital and at home; and periodic professional follow-up examinations. Hospitalization is limited to ninety days under Federal reimbursement; costs for additional days of care must be met from State or other available funds. For the present, only hospitals approved by the American College of Surgeons can be used. While Federal funds cannot be used to cover the costs of intercurrent acute illness, such as appendicitis and influenza, the Federal agency recommended that the State assume this responsibility in order to assure the success of the rehabilitation effort.

Provisions also are made for other professional personnel rendering services in physical restoration, such as graduate, public health and practical nurses; physical and occupational therapy technicians; mental hygienists, and dentists. Drugs and supplies, and the fitting and adjusting of prosthetic appliances are also indicated in this program.

The Michigan Program

The basic philosophy of H. Earle Correvont, Chief of the Rehabilitation Division, State Board of Vocational Education in Michigan, is "what is right! what is fair!" He is a firm believer in decentralization in any governmental project. The field worker who is in personal contact with the applicant for rehabilitation services is in a much better position to process the program than could anyone in Washington. Mr. Correvont believes in the family doctor. He insists that economic need is the main criteria in the consideration of every applicant for rehabilitation services. No one can deny a request for services when based upon economic need. While Mr. Correvont is in charge of the State program the medical profession can be assured of his full co-operation and a sensible administration.

Up to this time about ten per cent of all persons receiving rehabilitation services have been given some form of physical restoration. It is estimated that in the future this will increase to at least 25 per cent. During the year, July, 1943 to July, 1944, 108 cases received physical restoration, principally the correction of hernias, disabled limbs, deafness, defective vision, back injuries, arthritis, and cardiac involvements. Surgery or other medical treatment was provided in approximately half the cases, while some form of prosthesis was required in sixty-two cases. During the three months, July, August, and September, 1944, these services jumped to 104 cases; an increase of 400 per cent. The bulk of persons served were men in the middle years, 75 per cent being above thirty years of age. This suggests that the state agency is helping return to employability a considerable group having others dependent upon them, thereby relieving the demand for prolonged public assistance. The expanded Federal participation in the program is the chief reason for this increase.

Economic Need

A significant factor, and possibly a correct sociological principle, in the expanded Federal participation, involves consideration of economic need on a somewhat different basis than that of pure indigency. After his period of training, a rehabilitated person must be self-sufficient and self-sustaining. Therefore Federal regulations rule that personal property within a reasonable amount and nonincome-producing assets shall not

be considered in establishing economic need. A broad interpretation of this Federal ruling would result in a marked increase in the number of persons qualified for these services.

Fee Schedules

In payment for physical restoration services, Federal regulations rule that "Federal financial participation will not be available for costs incurred at rates which exceed those paid for similar services in programs under State supervision, such as crippled children or workmen's compensation." Mr. Correvont insists that it is not right or fair for one state agency to pay more for similar services than another state agency.

On January 26, The Council of the Michigan State Medical Society approved the principle of a uniform fee schedule for medical services purchased by all state agencies. This action is the result of the report of a study committee which not only considered and compared existing fee schedules, but also recognized the trends of Government in the field of medical care. This trend is toward governmental absorption of indigency medicine. The physical restoration service in the vocational rehabilitation program is an example of this. The action of the MSMS means that the doctors of medicine in Michigan will supply services to any ward of the State on the basis of a uniform fee schedule, regardless of what department the patient comes under. Specifically it is not an indigency medical fee schedule.

No matter what his economic status is, the patient expects to get a good quality of medical care. Any governmental agency which contracts for medical services expects to get this type of care for its wards. Substandard medical care for a price has no place in the system of modern civilization.

You county secretaries and guests must go back to your membership and advise them that for wards of the government, the medical profession of Michigan has but one fee schedule, to be adhered to by all doctors of medicine and by all state and federal agencies. You must make it clear that if a governmental agency refuses to meet this reasonable fee schedule for medical care of its wards it cannot hope to receive quality medical care from the doctors of medicine in its area. Immediate and decisive action in this matter must be undertaken in certain counties of the State. Co-operation between govern-

mental officials and the medical profession is possible if placed on a reasonable basis.

The program of vocational rehabilitation has existed for twenty-six years. Michigan has participated in it for the past twenty-three years. Eligibility for services under the new Federal Law and regulations may be interpreted on either a broad or a strict basis. A broad interpretation of requirements will allow a very sizeable portion of the population—your patients—to become candidates for these services, and at fees which are below the cost of rendering them. In Michigan, eligibility for services is granted upon a strict basis of economic need. May it be kept so.

Basically this whole program is a medical one. It depends upon the full co-operation of doctors of medicine—those men and women who actually supply the services. To reach the ultimate objective of the program, the rehabilitation of disabled persons, all parties, the purchaser, the vendor, and the recipient must be fully satisfied with their part in it.

The present program in Michigan is being administered on a reasonable basis. The administrator of the program realizes the need for medical co-operation. He is receiving that, because the medical profession has confidence in the direction of his objectives. We agree with him that disabled individuals who are in need of rehabilitation and physical restoration, and who are unemployed or in the very low income bracket, must receive service. Their disability which prevents self-sustaining employment must be eliminated. If government assumes the responsibility for this restoration service, it must be fair and reasonable to all agencies and parties concerned. Assuming a mutually satisfactory agreement the medical profession will do all in its power to perform the modern miracle of making useful citizens out of the blind, the halt, and the infirm.

≡≡≡ **MSMS** ≡≡≡

*Ill fares the land, to disease and death a prey,
Where bureaucrats accumulate and doctors decay.*

OLIVER GOLDSMITH, M.D.

Social Security has long been used by political leaders to entrench themselves in power and to destroy opposition. Sickness insurance has been found to prolong and increase absenteeism due to disease or injury.

APRIL, 1945

The Effect of Estrogens on Bone Healing

By Paul J. Connolly, M.D.
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Kalamazoo College, 1933-1936; University of Michigan Medical School, M.D., 1940; Harper Hospital, 1940-1945 (Junior intern, Senior intern, Assistant Resident and Resident in Surgery).

■ It has been found that the skeletons of birds change markedly during their reproductive cycles. This is especially true of the female and can be duplicated by the injection of estrogens.¹⁶ Further, there is a marked rise in the blood calcium at the time of calcification of the egg, although, Marlow and Richert¹⁵ do not believe there is sufficient evidence to associate this rise with estrogenic activity.

Hyperossification of the long bones and a marked rise in serum calcium were noted by Landauer¹⁴ to follow the administration of estrogen to ducks. The average serum calcium rose to six times the control values and was accompanied by a rise in blood lipids, inorganic phosphorus and phosphatase.

Marlow and Richert,¹⁵ however, do not believe that the estrogenic compounds, in the amounts normally found in the body of the fowl, are instrumental in causing a significant change in blood calcium level. They further state that those who have demonstrated definite rises in serum calcium have used mammoth doses of estrogens over long periods of time. Avery² also found that large doses of estrogens were necessary to raise blood calcium levels and that these levels dropped to normal six days after discontinuing therapy. He also reported a marked variation according to the age of the birds. Changes due to sex and species were also seen by Landauer.¹⁴

In the series of Day and Follis³ rats in which definite skeletal changes were produced by estrogens there was also an increase in the concentra-

tion of serum calcium. The validity of this effect was further indicated by the tendency of serum magnesium to be increased.

It has been shown that the continued administration of large doses of estrogenic material to mice produces a higher concentration of inorganic substances in the femurs²¹ and the marrow cavities are invaded and largely replaced by bone.⁷ Similar changes occur elsewhere in the skeleton with the exception of the symphyses pubis, which tends to show resorption.^{5,20} There is normally a higher ash content in the bones of female mice as compared with male mice and this is thought to indicate the influence of the animal's own hormones on skeletal growth.²¹ It has also been shown that in estrogenically treated mice changes take place more slowly in males and is prevented by large doses of testosterone.⁸

Microscopically, bones of estrogenically treated mice show an absence of the columnar arrangement of newly formed trabeculae in the zone of provisional calcification. Instead of this arrangement, there is a disorderly agglomeration of blood vessels which have erupted into the growth plate and which have reached the level of the proliferating cells. Around the numerous blood vessels, new bone forms by means of osteoblastic activity in the connective tissue in the region of the zone of provisional calcification. There is a proliferation of new bone in the medullary cavities of certain bones and especially of the lower end of the femur and the upper end of the tibia. Other bones, including the calvarium, are also affected but to a lesser degree. The proliferation begins around the zone of provisional calcification and advances into the diaphyseal portion of the bone. These changes can be recognized on roentgenographic examination.²⁰ These animals tend to have a shortening of the long bones which Gardner found to be approximately 1 mm. in his experiments. He also found that the breaking strength of femurs of estrogen-treated mice was one half greater than that of untreated controls.⁶

In experiments on guinea pigs, rats and mice the Silberbergs discovered that the first change produced by estrogens in the guinea pig was a marked narrowing of the epiphyseal disks caused by an inhibition of proliferation and an increased calcification and hyalinization of the epiphyseal cartilage. In immature guinea pigs under the influence of moderate doses of estrogens the suppression of growth of cartilage was only transi-

tory and was followed by an enlargement of the epiphyseal plates associated with an increased proliferation of cartilage cells. In growing mice and in some rats such a stimulation of the proliferation of cartilage was not seen, but the phase of inhibition was soon followed by accelerated and intensified processes of retrogression and ossification. Resorption of cartilage and bone, however, was at first greatly inhibited. Thus the breakdown of the epiphyseal cartilage was delayed, the subepiphyseal trabeculae persisted for an abnormally long time and the shaft was thickened. By a coalescence of connective tissue or bone marrow cells, in contact with pre-existing bone, new osseous substance was deposited in the diaphysis of mice. These processes tend to the formation of an interlaced osseous network which encroached upon the marrow cavity in the direction from the subepiphyseal layer towards the diaphysis. This increased bone formation also involved the shaft and could lead to the occlusion of a great part of the marrow cavity.¹⁸

The chemical, histological and x-ray evidence collected by Day and Follis³ indicates that in the bones of growing rats given a continued excess of estradiol benzoate there is a decrease in the physiological destruction of bony trabeculae. However, the number and thickness of the individual trabeculae beneath the cartilage shaft junction are greater in the estrogen-treated animals. There appears to be an increase in osteoblastic activity at the cartilage shaft junction, but not elsewhere. Together this increases the density of the epiphyses and apparently accounts for the increase in the concentration of ash in the whole bone. However, as the total amount of bone is reduced owing to decreased growth in length there is a reduction in the total dry weight and the ash weight of the bone. Since the alterations in bone occur principally in the epiphyseal portion it is probable that determinations of ash concentration in the epiphyses would reveal considerably larger changes than in the whole bone.

Albright¹ divides the calcium deficiencies of the skeleton due to metabolic disorders into those due to increased resorption of bone and those due to decreased formation of bone. Deficiencies due to decreased formation of bone are further subdivided into those in which calcium is not deposited in osteoid tissue (osteomalacia or rickets) and those in which the osteoblasts are primarily deficient in laying down osteoid tissue. The latter

is osteoporosis. Of forty-two of his patients under the age of sixty-five with generalized osteoporosis, forty were women who had gone through the menopause; only two were men; there were no cases in women before the menopause. It was then noted that estrogenic therapy produced a beneficial effect on the retention of calcium in postmenopausal osteoporosis.

Pollock noted the striking frequency with which ununited fractures of the femoral neck occurred in women more than sixty years of age.¹⁷ This with the high incidence of senile osteoporosis of the spine in women more than fifty years of age and the occurrence of similar changes in the lower end of the radius in the same age group led him to speculate on the estrogens as a causative factor. Under anesthesia he fractured the right humerus of a series of rats. In a group of healthy, nonspayed rats callus was present in 50 per cent by the end of the third week following fracture. In rats that had been spayed no callus was found at the end of twenty-one days. In rats that were spayed and then treated by huge doses of theelin calcification was present in 50 per cent by the 14th postoperative day and in 75 per cent by the twenty-first postoperative day. In the younger age groups, confirmatory findings were obtained.

In another series of similar groups healing of the fractures was studied microscopically but no appreciable differences in the early stages of repair of bone could be demonstrated. The impression was gained, however, that injection of estrogenic substance stimulated production of endosteal osteoid tissue.

Hills and Weinberg¹² fractured the radii of thirteen cats and then gave them theelin. Six weeks after treatment the other leg was fractured and healing followed without theelin. Nine treated cases showed earlier and more extensive callus formation. One showed the same on both sides. Three showed greater callus formation on the untreated side.

Seven dogs were similarly treated. Six showed more callus formation on the treated side. The seventh showed more callus on the other side but was found to be pregnant during the time the untreated side was healing.

Hills and Weinberg also treated three cases of delayed union fracture in human females aged seventy, thirty, and nineteen. The patient aged nineteen gave a history of irregular menses. All

had good results after theelin therapy. The effect of the estrogenic material upon the three patients appeared to be more striking than the effect upon the animals. They believe that this may be due to the fact that in the humans they were attempting to rectify a definitely abnormal type of bone repair, whereas in animals they were attempting merely to exaggerate the normal process of healing.

It should be noted that in the animal experiments where best results were obtained (six out of seven dogs) smaller comparative doses were given. This was because of information from Albright stating that in osteoporosis of the spine he had found that it is possible to produce a positive calcium balance with small doses of estrin, but that large doses may produce a negative calcium balance. Albright is quoted as using 10,000-30,000 international units per week in the average 150 pound patient.

This may be why Johnston¹³ who gave between 12,000 and 36,000 units of estrogenic substance to apparently normal girls at puberty was able to produce a depression of the calcium balance in five instances referable to an increase in both the urinary and the fecal fractions. One other girl given stilbesterol had the same results. All six subjects were producing normal amounts of estrogen and the effect was that of an excess.

The same results in animals were obtained by the Silberbergs who found that with prolonged administration of estrogen, solution processes are resumed and ultimately lead to absorption of the excessive bone present at the earlier stages.¹⁹ They also report that estrogen is most effective in an oily solution if injected subcutaneously, less effective if applied in an ointment, and least effective if injected as a saline solution. A smaller number of relatively large doses of estrogen, given over a short period of time, was said to be more effective than an equal amount administered in smaller doses over a longer period of time.

Estrogenic hormones were administered at Harper Hospital to eighteen patients with various types of fractures. Of this number nine were followed sufficiently long to form some idea as to the value of therapy.

Case 1.—A white woman, aged twenty-three, with menstrual irregularity. Nonunion had been present for seven years with formation of a pseudarthrosis following a compound fracture of the tibia. A bone graft

EFFECT OF ESTROGENS ON BONE HEALING—CONNOLLY

four years previous had been unsuccessful. Another bone graft operation was performed and theelin started. Fifty-five days later when the next x-ray was made and after getting 210,000 units of aqueous theelin there

fracture of the same bone and was treated by plaster moulds and casts. Theelin was started a week after the fracture occurred and 1,950,000 units of the aqueous suspension were given in eighty-eight days. There was

TABLE I.

Case	Age Sex	Fracture	Treatment	Began	Theelin Period (days)	Total	Callus Appeared	Guarded Use or Cast Removed
1	23 F.	Tibia	Bone graft	7 years	92	260,000 u.	55 days	
2	49 F.	Tibia		9 mos.	87	1,150,000	2 ¼ mos.	
3	51 M.	Tibia	Metal plate saucerization	7 mos.	32	400,000		
4	51 M.	Femur	Cast	1 wk.	88	1,950,000	1 mo.	4 mos.
5	72 F.	Femur	Skin traction	3 days	52	750,000	3 wks.	71 days
6	50 M.	Femur	Skeletal Traction Lane Plate	2 mos.	131	1,000,000	9 mos.	
7	50 F.	Femur	Smith Peterson Nail	11 days	52	200,000 (oil)		5 mos.
8	44 F.	Tibia Fibula	Skeletal Traction cast	25 days	14	180,000 (30,000 in oil)	5 wks.	3 mos.
9	63 F.	Tibia Fibula	Skin traction cast	10 days	16	450,000 (Aq.) 10,000 (oil)	3 wks.	
10	80	Clavicle Femur	Smith Peterson Nailing	2 days	26	700,000		

Theelin for this study was supplied through the courtesy of Dr. Sharpe of Parke, Davis and Co.

was callus formation about the graft and the fragments. This was still increasing four months later.

Case 2.—A colored woman, aged forty-nine, had a minimal amount of callus formation about a fractured tibia, with considerable porosis of femur, tibia, and fibula, nine months after the fracture occurred. Theelin was started in doses of 50,000 units of the aqueous suspension twice a week. In one month there was a decrease in the amount of atrophy of the bones although six months later there was still very little callus formation. Theelin was given for three months.

Case 3.—A white man, aged fifty-one, had a fracture of the tibia and fibula treated for three months by immobilization in a plaster cast. Internal fixation with a metal plate was then performed. The wound drained purulent material from the time of removal of the sutures. The plate was removed three months after the insertion. Seven months after the fracture occurred theelin was started. Saucerization of the tibia was then done and two weeks later the wound was cleaned out and packed with sulfathiazole. Four hundred thousand units of aqueous theelin were given in thirty-two days. Bony union developed between the fibular fragments but seven months later the wound was still draining and there was no satisfactory bridging of the tibial fragments.

Case 4.—A white man, aged fifty-one, had an ununited fracture of the neck of the left femur which had occurred four years before and was held in place by fibrous tissue. The patient then suffered a supracondylar

very little callus formation in one month but in two there was considerable and in four months there was sufficient to permit use of the part.

Case 5.—A white woman aged seventy-two, who had a fracture of the femoral neck one and one-half years previous, fell fracturing the same femur spirally in the mid-portion of the shaft and in a linear manner through the lower portion of the shaft. She was treated with a Russell traction and given 50,000 units of aqueous theelin twice a week for a total dosage of 750,000 units. Three weeks after the date the fracture occurred there was considerable callus formation present. In seventy-one days there was not quite sufficient callus to permit of weight bearing but the patient needed no support to the leg except in walking. Eleven days after the last dose of theelin the patient began to have vaginal bleeding which had been absent for twenty-five years. This lasted three days. Curettage specimens revealed normal endometrium, and the patient had no further trouble. This is the only case of withdrawal bleeding that occurred in this series.

Case 6.—A white man, aged fifty, fractured a femur transversely at the junction of the upper and middle thirds and obliquely in the lower third of the shaft. Skeletal traction was used followed by open reduction and insertion of a Lane plate. Callus first appeared two months after the accident, but in nine months there was still very little callus. Aqueous theelin was then started, 50,000 units being given weekly for a total of 1,000,000 units. Monthly check-up rays revealed considerable in-

creases in callus, and six months later there was solid bony union of the distal fracture, but the union of the proximal femoral fracture was as yet incomplete.

Case 7.—A white woman, aged fifty, sustained a subcapital fracture of the femur. A Smith-Peterson nail was inserted and the patient given daily injections of 10,000 units of theelin in oil for a total of 200,000 units. Five months after the fracture occurred there was sufficient union to permit of the patient's use of the leg in a guarded manner. After eighteen injections the patient ran a temperature elevation of 100-101 degrees. This dropped to normal two days after discontinuing theelin.

Case 8.—A white woman, aged sixty-three, had a comminuted fracture of the lower third of the tibia and of the middle of the fibula. Skeletal traction was applied followed by plaster cast. She was given 180,000 units of theelin, 30,000 in oil and 150,000 aqueous. Callus was evident in five weeks, and plaster dressing was removed in three months although weight bearing was not permitted.

Case 9.—A white woman, aged sixty-three, had a comminuted fracture of the proximal tibia, distal fibula, and clavicle. Skeletal traction was applied and 50,000 units of aqueous theelin given every other day until 450,000 units had been given. Three weeks after the fracture there was sufficient callus to remove the traction and the patient was discharged in a plaster cast.

While this series is too small to form any definite conclusions, nevertheless definite tendencies were noted. All of the patients were middle aged or over with only one exception. Three of the patients were men, and of these two had fractured femurs. One (Case 4) healed quite rapidly in spite of the previous nonunion. The other (Case 5) had very little callus in nine months when treatment was started. Callus then formed more rapidly and one of the fractures united solidly but the other incompletely. The third case was complicated by osteomyelitis and the results, as would be expected, were not good.

Of the six women treated, the best results were obtained in the elderly and especially in those with some demineralization or generalized osteoporosis. The osteoporosis tended to improve as the callus appeared.

In this series of a total of eighteen cases there were only two complications attributed to the theelin therapy. One was a case of withdrawal bleeding in a seventy-two-year-old woman given 750,000 units of aqueous theelin in fifty-two days. Curettage revealed only normal endometrial tissue. The second was a low-grade temperature elevation in a fifty-year-old woman receiving daily injections of 10,000 units of theelin in oil.

Two days after discontinuing therapy the temperature returned to normal.

In a series of 206 women given estrogens in amounts varying from 500,000 I.U. to 23,000,000 I.U. an orderly regeneration of the epithelial, glandular and stromal elements occurred according to Geist and Salmon.⁹ Doses over 1,500,500 I.U. per month usually resulted in the appearance of cystic glands. They concluded that "there appears no evidence to justify the fear that carcinoma of the genital tract may result from the therapeutic use of estrogens."

In the male the estrogens produce azoospermia with gradual enlargement and hypertrophy of the breasts and loss of libido when large doses are given. None of these effects are permanent, and after treatment is stopped the breasts and nipples gradually return to their former state.^{10,11} Dunn has found that 300 to 600 mg. of stilbesterol given to hypersexual males causes loss of libido and produces moderately advanced degenerative changes in the seminiferous tubules. Discontinuance of stilbesterol therapy for nine to sixteen weeks resulted in regenerative reaction of the degenerated seminiferous tubules and reappearance of sexual impulses at a subnormal level.⁴ This gradually progresses to the former levels.

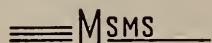
Conclusions

1. There is no danger of giving moderately large doses of estrogens to either men or women, providing examination is made to rule out pre-existing lesions such as breast or genital carcinoma.
2. Estrogens will reduce osteoporosis.
3. There is a tendency in older individuals for faster callus formation and quicker bone healing in fractures in patients given theelin therapy. This is especially true of elderly women.

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Tropical Diseases in America After the War

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Tropical disease has been until recently comparatively rare in most sections of the United States, especially in the north. As month by month more veterans are returning from various battle fronts and being gradually absorbed into the community, they are certain to bring with them many diseases with which the average practitioner has naturally not had much previous experience. This paper discusses briefly some of these conditions and the need of all physicians to be tropical-disease conscious.

■ "ISOLATIONISM" is a term which was not only applicable politically to many folks and sections of America, but, until we actually entered this war, most of the doctors of this land have been little interested in fields of medicine that were not directly concerned with the problems of their own community or their own specialty.

This is entirely natural, for the average practitioner had so many local problems to solve, in the proper diagnosis and treatment of his patients, that he had little time or energy to expend on vague subjects such as "Tropical Medicine," fascinating as such subjects might be. If he was living in one of the Southern States and saw an

occasional case of malaria, he would keep up with progress in the treatment and diagnosis of that disease, but with that exception, "Tropical Medicine" was literally a closed book.

In addition to a few investigators and teachers of medicine who are interested in that special field, the only other group of men in the United States who have continually and consistently throughout the years kept abreast of the important subject of tropical diseases, are the doctors of our Army and Navy. Even that interest has been stimulated, and through them the interest of the doctors of the nation, by war and the diseases encountered in war and in war areas.

Those of us who are old enough to remember the Spanish-American War recall how typhoid fever, malaria, yellow fever and the dysenteries caused many more deaths than any actual military operations. Many of these deaths occurred here in the United States in training camps before the men had embarked for the combat areas, and in light of the knowledge of today, we know that most of these deaths were preventable. The names of General Gorgas, Major Walter Reed, Dr. Lazear and others will go down in history for their courage and brilliant studies in this period and the years following. This interest in tropical medicine continued and expanded as the Panama Canal was dug, the Philippines occupied, and Cuba developed.

As far as the United States was concerned, World War I was fought in temperate zones, typhoid fever was controlled by inoculations, typhus was seen in only a few areas, and so tropical medicine was neglected in favor of more dangerous diseases of the time, influenza, meningitis, trench fever and pneumonia.

Today the entire situation is changed, this is indeed a WORLD war, and our interests and vision and thoughts must be world wide; boundaries have been abolished, time and space have been obliterated, and the modern man of medicine must be prepared to recognize disease which may have originated in a land 10,000 miles away; he must be ready to treat conditions, the name of which he has not heard since his days as a student; he must realize that "tropical" medicine has left the tropics, and that so-called "tropical" disease need not always be referred to the specialist.

Tropical disease will be brought to our land, not only by the returning veteran but also by the thousands of civilians, some engaged in war

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work, and some not, who are dashing from country to country, at great speed, carrying on their necessary work, and sometimes, if not actually carrying disease, carrying the vectors of disease from one land to another.

The modern airplane is a genuine factor in this transmission of disease, because of its great speed. Twenty-five years ago, it took us three months to go from here to Iran; last December our daughter made the journey in an Army bomber in less than a week. Folks fly from San Francisco to Australia in three days, from India to America in the same time. Commander Hudson⁶ tells of a Navy man coming to the Washington Dispensary with a sand flea (*Tunga penetrans*) between his toes—he had brought it from South America without noticing it until he arrived here. The *New York Times*¹¹ reports a new eye disease spreading in Mexico, caused by an African mosquito. Dr. E. R. Kellersberger⁷ calls attention to the fact that the disease referred to "onchocerciasis" is common in Mexico and Guatemala, as well as in Africa, and resents it that the African mosquito is blamed for the present epidemic in Mexico! The areas in Mexico and in Guatemala where this disease is endemic, are not far from the proposed Pan-American highway, and thus it is easy to picture how this disease could be carried north into our own country.

Onchocerciasis is a parasitic infection, producing tumors or subcutaneous nodules anywhere that the gnat or mosquito may bite the individual, usually around the head, especially in the scalp, and thus producing inflammatory lesions in the eyes, which may cause keratitis. Diagnosis is by examination of the skin scrapings, which should reveal the microfilariae, and treatment is excision of the tumor or tumors.

Never before in American history have there been as many Americans abroad in as many countries; and, as many of these are in the tropical and subtropical lands, it is natural that in the minds of the laity as well as among doctors, there arises the question of how much tropical disease may be brought back by returning troops, and how much danger there will be to the country as a whole.

We must admit that the danger is not merely theoretical, but on the other hand we must realize that many of the tropical diseases are such that it is very doubtful if any of our troops will be affected, and if they do contract the disease, it is doubtful that it will be transmitted to others. Some

of you have probably read that splendid book "Who Walk Alone," well written by Perry Burgess.² It tells the sad story of a young American soldier who acquired leprosy during the Spanish-American war, and the subsequent course of his disease. This book is based on an actual case, but there is very little danger that any of our troops will acquire leprosy, for in order to get this disease one must have constant prolonged contact with a leper in the active stage of the disease, and it is acquired usually only by those whose general health is poor due to malnutrition, malaria, tuberculosis or some other chronic disease. Our troops are given such excellent medical care in this war, that we doubt much if any will develop leprosy.

The various helminthic diseases produce conditions which sometimes are serious but often may be of lesser importance. The one disease that is causing considerable worry because of the great number of men infected, and the rather hopeless prognosis, is filariasis Bancrofti. Hundreds of men have been evacuated from the Pacific islands infected by this nematode, and although in many the infection does not seem to be very serious, yet one hesitates to give a prognosis that may be too favorable. Several weeks ago, a young marine, a neighbor, stopped in to see me because of this condition; his symptoms had entirely subsided, and the one natural question which troubled him, was, should he marry, and, if he married, might he become a father. The psychosomatic manifestations of this disease are serious, and are adequately discussed by Rome and Harwood¹³ in the *Journal of the American Medical Association*. This disease, as you know, is transmitted by the mosquito and the adult filariae inhabit the lymphatic vessels and glands, from which large numbers of active microfilariae are discharged into the lymphatics and thence into the circulating blood. Thick smear examinations may reveal the microfilariae. Several types of mosquitoes transmit the disease, the chief one being *Aedes Scutellaris*.

In the early stage of the disease one finds a recurrent lymphangitis, and lymphadenitis; the lower extremities are most frequently affected, then the scrotum and vulva; there is often a secondary dermatitis with cellulitis and fever. In countries with poor medical service the scrotum may attain a tremendous size; elephantiasis may result with great deformity as well as severe pain. You will probably not be called upon to make the

original diagnosis of filariasis, but you may be called upon to advise men who have had the disease. The vector of the disease may possibly be brought into this country but we should be able to control it.

The various intestinal worms are not so important for even though some of our men should be infested by ascaris, or hookworms, or tapeworm, upon return to a land where sanitary conditions are improved, where nightsoil is not used as a fertilizer, and where meat is inspected, we would not expect such disease to spread.

In the same way one would feel that because their vectors are not common in this country, that such conditions as leishmaniasis, trypanosomiasis and schistosomiasis would not be liable to spread to this country. Yet we find a report⁴ of two cases of schistosomiasis that were picked up at Ellis Island this past year, both in Arabs from Yemen. Certainly when our troops return from lands where parasitic disease is endemic, they should have thorough stool examinations, that such diseases be not spread. If, however, some of our returning troops should have cutaneous leishmaniasis (oriental sore, Baghdad boil, etc.) others might acquire the disease for it may be spread by the ordinary housefly, or by sand flies.¹ It is not a disease that produces fatalities, but if not properly diagnosed it may last a long time, and leave a hideous scar.

Sand-fly fever (phlebotomus fever) is probably more of present military importance than of future danger, but there is a definite danger that the vector (phlebotomus papatassii), may be spread in the United States as it is found now in so many sections of the world. A very excellent discussion of this disease will be found in the recent article by Sabin and Philip.¹⁴

Dr. G. B. Eusterman⁵ of the Mayo Clinic feels strongly that the possibility of the spread of tropical disease in America is very great, and writes:

"In this country we are *already* facing an imposing array of disorders of protozoal, parasitic, bacillary, helminthic, virus, rickettsial and fungus origin. Many strange and some familiar vectors in the shape of fleas, lice, ticks, mites, mosquitoes, chiggers and maggots, to say nothing of rodents, are concerned. Considering the inadequacy of our educational training in tropical medicine in the past, and the important role of laboratory diagnosis, the rank and file of the medical profession rightfully doubt their ability to wrestle with the many and varied problems with which they will *shortly* be confronted."

He feels that kala-azar, and schistosomiasis (or bilharziasis) are liable to be found here in America after the war.

Lt. Colonel Thomas T. Mackie⁹ of the U. S. Army also feels that this subject is a very important one and writes:

"The magnitude and ultimate significance of the problem presented by *latent* infection and the carrier state among military and naval personnel cannot be evaluated. The similar problem presented by refugee peoples in mass emigrations from war-devastated areas cannot even be estimated."

In this war, more even than in previous wars, armies will become mobile reservoirs of infection. The millions of men actually involved are greater than in any previous struggle, and the speed of modern mechanized warfare makes it impossible for even well-organized medical units to protect the individuals under their care from disease. They can and do vaccinate the men against smallpox, typhoid and paratyphoid, tetanus and even yellow fever, and this protection is real. But the vaccination for typhus, for cholera, and for plague is still in a more or less experimental stage, although it is getting to be of more value year by year.

Against many other conditions, the men are not immunized, because there is no adequate immunization available yet. Prophylactic treatment against malaria is still controversial, and protection against the dysenteries and many other conditions is yet primitive.

Our Government feels that practitioners in America should be prepared to diagnose these various tropical diseases, and you will note frequent articles sent out by the Subcommittee on Tropical Diseases of the National Research Council. In a recent article in the *Journal of the American Medical Association*¹⁰ the committee concludes: "It is recommended that both physicians and health departments prepare themselves for the diagnosis, treatment and *control* of disease brought back by returning military personnel. . . . State and local societies can aid by devoting programs to this field."

Dysentery is one of the diseases which is liable to be found anywhere in this country, for although it normally runs an acute course, a certain number of the troops who acquire the disease will become carriers. Bacillary dysentery has been the cause of many deaths and great morbidity in the South Pacific area; thousands have had the dis-

ease, most have been cured, but in some a chronic condition has developed which has necessitated hospitalization here in the United States. Others, apparently well, may live in a community and be a source of danger because they are carriers. Although more frequent and often more virulent in the tropics, it may be found in any land. Its distribution is hygienic rather than geographical, and it tends to follow armies, and also tends to prevail in institutions, such as orphanages or insane asylums.

Many epidemics of bacillary dysentery occur, especially in Japan, and lands occupied by the Japanese. Bad sanitation, malnutrition, exposure, fatigue, and errors of diet and drink are predisposing causes, and thus it is readily seen why soldiers on active duty are prone to get the disease. If you have a patient with a chronic diarrhea, and with rather vague abdominal symptoms such as indefinite, irregular pains, cramps, indigestion, etc., etc., it is well to examine the stool (a fresh one).

The disease is ordinarily acquired, as is typhoid fever, by the ingestion of faeces, either with food or drink. Those attending the patient are very liable to have their hands contaminated with infectious material, and the more primitive the sanitary facilities the more rapidly an epidemic develops. As in typhoid, flies may transmit the disease, in fact, the old typhoid teaching, of the three F's, "Food, Fingers and Flies," applies just as truly to bacillary dysentery. This is not the time to discuss the treatment of the disease, but I might mention that sulfanilyl-guanadine has been shown to be of great value in treatment. Probably chronic conditions and carriers may be lessened by the wise use of the sulfa drugs.

Amebic dysentery deserves even more attention for it is much more likely to become chronic, and the *Endamoeba histolytica* may often be found in the stools years after a definite attack. Several of our Iranian missionaries, returning to America on furlough were surprised to learn that they harbored the ameba, even though their symptoms were very indefinite. Amebiasis produces not only the diarrhea, but the organisms may metastasize through the portal veins to the liver, producing abscess. Although more frequent in tropical countries, it is commonly found in the temperate zone. You will recall the outbreak of amebic dysentery in Chicago in 1933, in connection with the Century of Progress Exposition.

There were more than 1400 known cases, with fifty-two deaths. Two-thirds of the cases became apparent outside of Chicago, in fact in 206 localities. They were all probably due to polluted water supply of two Chicago hotels. The following year in the same city, 100 cases of amebic infection were found in firemen who drank water polluted with human excreta, while fighting a fire in the Union Stock Yards.

Any person returning from the tropics, who gives a history of occasional diarrhea, blood in stools, and abdominal pains should be suspected of amebiasis, and a careful stool examination should be made. As in typhoid fever and in bacillary dysentery, food, fingers and flies may be the methods of transmission of the disease. Drinking water becomes contaminated by feces containing the cysts, or the droppings of flies, or cockroaches may spread it. Like the two other diseases mentioned, it is a disease of filth; one gets it by eating or drinking human manure.⁶

Treatment will not be discussed here in detail but emetine hydrochloride is still the most useful drug known for this condition. This drug is very toxic and the patient must be watched lest you kill him with the remedy! The margin between the toxic dose and the therapeutic dose is small. The arsenic compounds are also used, and they are less toxic than emetine.

Time will permit the discussion of only one other "tropical" disease, and yet that is probably the most important one of all. Many authorities feel that it is the number 1 problem of the post-war world, the greatest danger, not only to our land, but to others. I am referring, of course, to MALARIA. Dr. Strong¹⁵, in his new edition of Stitt's "Tropical Diseases," starts out on page 1, volume 1, section 1, chapter 1, with the statement: "From the standpoint of prevalence, malaria appears to be the most important of all diseases in the world today." It is indeed the great scourge of this present war, for its prevalence among combat troops has been so great, with tremendous morbidity, and pathetic mortality, that it has caused the loss of battles as well as of men. No other infection causes more morbidity in the world today than malaria, and it is the one "tropical" disease that is liable to be found in America in great amount after this war.

Much has been written about malaria in World War II and I would not endeavor to give you even a partial bibliography of all the material.

There are a few facts, however, which we must emphasize:

1. Neither quinine or atebine will prevent malarial infection, but given "prophylactically" they usually prevent clinical symptoms, and allow the patient to carry on their job as long as they continue to take the medicine, but they may come down with what is often a severe active case as soon as treatment is stopped.

2. Malaria, like syphilis, may simulate nearly any known disease, and thus it is often difficult to diagnose, although the ordinary case has the classical symptoms. A patient with malaria may have severe abdominal pains such as produced by an acute appendicitis, he may have such severe vomiting and distention that one may think of intestinal obstruction. In other cases the symptoms resemble those of meningitis or encephalitis, while others imitate an upper respiratory infection. If I may be permitted to offer a personal case, I would cite that of an adult in apparent perfect health who without any prodromal symptoms, passed 1,000 c.c. of bloody urine; three days later the testicle swelled to the size of a baseball, and the temperature went up to 105; there were no chills, there was no enlarged spleen, but the patient, as proved by a thick blood smear, had malignant malaria (black water fever). He responded to intravenous quinine therapy, and although continuing to live in a mosquito-infested semitropical land for two more decades, he had no further attacks of malaria (I happen to be the patient).

The United States Public Health Service recognizes the possibility of local outbreaks of malaria starting from relapsing cases acquired abroad. Many of the early cases sent back from the Pacific front, and also from North Africa, were soon released from the Army; now, however, they are usually kept in hospitals until the doctors feel there is little possibility of a relapse.

Be malaria conscious, for you may see some cases in the near future, be tropical-disease conscious, for only by keeping these conditions in mind will you be able and ready to diagnose them when you see them. The two-volume book by Stitt which I have already mentioned is a splendid addition to any doctor's library; if you wish something briefer, I would suggest an article which appeared in *War Medicine*, in July, 1941¹² regarding the treatment and control of certain tropical diseases. Even the laity are now being

informed about tropical disease, and popular presentations such as recently appeared in *Life*³ may act as a brief review for the medical man, who has not been tropical-disease conscious. Much has been written recently about malaria, and the Circular Letter No. 153 from the Surgeon-General has much valuable information on the subject.³

The doctors of America, I believe, will be ready and capable of handling the problem of tropical disease when it comes. It is, however, a bigger problem than just America; it is a problem involving the entire world, for when hostilities cease, there will be mass emigrations of oppressed civilian populations from many Axis-occupied countries; they, plus the various troops returning to their countries, will spread disease, import vectors, promote epidemics.

We all know that peoples who are decently housed, properly fed and adequately clothed, can resist disease much more readily than those who are starved, and living in filth and dirt. We must have a part in feeding and clothing the world, not only for their protection, but for our own safety. Their disease will become our disease, and their good health will become ours. We must teach them hygiene and sanitation, we must show them how to provide clean water for themselves, and how to build latrines; they must be shown the advantages of proper screening, they must learn about preventive inoculations; they must realize that flies, mosquitoes, bedbugs, rats, lice, all are more dangerous than enemy soldiers, and must be destroyed. Then and then only will America be free from the repeated invasions of tropical disease.

Summary and Conclusions

1. The average practitioner in the USA is not "tropical-disease" conscious, and thus needs to review and modernize his knowledge of the subject.

2. Tropical disease will be, and in fact is being, brought to this country by returning military personnel, and others who have been living abroad.

3. Modern airplanes travelling so rapidly carry vectors of disease as well as people who may be carriers of certain organisms.

4. Leprosy, trypanosomiasis and some other

(Continued on Page 391)

Radio Advertising by the Medical Profession of Michigan

Series II of the Michigan State Medical Society's commercial radio programs was inaugurated over Station WJR, Detroit, on Friday, February 16.

"American Medicine" is on the air for fifteen minutes every Friday at 7:15 p.m. EWT. The program includes music, song and story, and features a contest in which the public is invited to report personal experiences involving doctors of medicine. This pleasant and interesting musical prescription includes a short message "from your family doctor" stressing the value to the people of the time-tried private practice of medicine and the preservation of the physician-patient relationship. In addition, the announcer reiterates this statement weekly: "No theoretical plan, government-controlled and operated, and paid for by taxation, should replace the present system which permits you to choose your own doctor."

"American Medicine" is on the air for twenty weeks—to the end of June.

Tune in on WJR every Friday, 7:15 to 7:30 p.m. EWT. Far more important, urge your patients, friends and acquaintances to listen to "American Medicine." They will find this quarter hour an enjoyable and entertaining period. Further it will be profitable to them in a *double* sense.



President, Michigan State Medical Society



President's



Page



Editorial

RUGGED INDIVIDUALS

■ One thing made America great. Her people came to this country for the sake of liberty—a chance to live their own lives—to make their own way. Her pioneers feared no hardship if it led to their advancement, to the establishing of homes and means of livelihood. They braved the terrors of unknown lands, the storms of sea and sky, the wars of nature and savage. They worked for a living, and many amassed a competence for their old age, or for their families. They knew no master and no overlord granted them privileges or favors. They were independent in all that word rightfully implies.

Our pioneers established communities, law and order, government. They built roads, schools, churches, all for their own betterment and to make the earning of their own living so much more secure and easy. They declared their independence and set up their own country upon sure and solid standards. They taught their children to respect their national heroes, their national customs, to honor their proven leaders.

During the youth of the nation it was a matter of supreme pride to be able to do for one's self, to establish a family and home, and to provide for that home. To be dependent "on the town" was abhorrent, and indicated a woeful lack of "what it takes" to be a *man*. Self-esteem meant the ability to provide for one's own wants.

But that is all changed when we have finally "grown up." What we are told we want now is not the chance to furnish security for ourselves, but that security guaranteed to us by a paternalistic government. We are told we want the "four freedoms" rather than the opportunity to go out and earn those four freedoms, and a lot of others.

America, if she is to fulfill her proper destiny, must make the effort to earn whatever freedoms she may want at any time. She must make the ambitions of her sons such that they will go out in the markets and fields and shops and make their own way. They must be haunted by a fear of failure rather than a fear that the four freedoms will pass them by unless they are guaranteed. A man's own determined effort is his best security. He should demand a chance to *earn* his

living, liberty, happiness, secure his health; not to have it thrust upon him.

Jobs with sufficient earning power to provide and guarantee our living, liberty, health, and happiness are the ideal goal. The American way is to choose our own doctors, not to be assigned to them. Voluntary nonprofit health plans guarantee this privilege.

Such is the ideal for which we are striving. Society owes its members the opportunity to so provide for their services.

Listen! WJR, Fridays, 7:15 p.m. EWT, MSMS Program!

WHAT ARE WE FIGHTING FOR?

■ This is a country steeped in Liberty, Independence, Self-determination. We are told we are in this war to preserve our American Way of Life.

Yet we are faced with encroachment on our rights and ideals with directives and more directives. We see government reaching out ever more to guide and direct our work and our lives. There has been so much coercion, so much insidious boring from high places that a committee of our State Medical Society attempted to ascertain just what our members want done in the matter of protecting American medicine.

We know pretty well what our home front is thinking, also what they are individually doing and not doing to protect their very professional life. What do our brothers in the service believe and how do they feel? Are they satisfied with conditions as the trends now point? Here are excerpts from a letter in reply—one of many. Naturally, the name cannot be given, but we have the original letter on file:

"I received the literature on the pending bill (Constitutional Amendment) to be placed before the people of Michigan. Enclosed is the signed card to show my stand on the matter. It is hard to describe how I feel tonight. After reading the enclosed literature, it makes me wonder what this war is about. I cannot give the answer, for every bit of information that comes to me is something radical, something new, something out of another world, that I cannot understand.

"We were told that we were to fight this war to preserve our America, our country. What are we going to find when we come back? Is it all going to be

changed to suit those that remained out of the war—those who did not get in and do as we are doing—not much but what Uncle Sam has said for us to do? We have taken it on the chin, only to find every move that is made back home is one against us, so radical, so hairbrained as to upset us the same as so many other countries have been.

"I sit here tonight not knowing what will happen to me tomorrow, where I will go, or what command will be given. But that is war and it must be thus if we are to win. But to sit here and wonder what is in store for me in my own state, in my own home, in my own life—is a thing that is hard for me to have to take.

"I was happy when I entered the Army. I am not a young man, yet I was willing to start over when this is over, for I felt that I should. Will there be anything for me to start with, a man in middle life, broke, having sacrificed everything but love of country, and duty. I sit in a lonely room and think of what someone is trying to do to the things we live for and have spent half of our lives for. What is the answer? As far as I am concerned I am just one of all of us.

"Who is back of this thing? Doctors who are not in the service? Men who are looking for employment in the setup? Crackpots? I do not find one word as to who is back of this thing. I feel we should know. Is it some secret group just putting something over?

"I know that you and a lot of others are fighting for the right, but why do you have to do all this? And why do we have to worry about it over here?"

There is our problem stated by a disillusioned, discouraged brother who fears for his future, who is beginning to mistrust his brothers at home, fearing he has been "sold down the river."

We all know the tricky, sly, insidious inching into our rights as citizens, as free men, taking a bit here and a bit there—always getting closer to the ultimate goal.

Have any of us sat back and thought "that can't happen here"—"why should I worry—let the officers look after those things. That's why they are officers."

Remember the J. Hamilton Lewis Bill, the Wagner-Murray-Dingell Bill, the EMIC, the proposed Constitutional Amendment—Where will it end?

Listen! WJR, Fridays, 7:15 p.m. EWT, MSMS Program!

WE MAY BE PROUD

■ John F. Hunt says: "You people in Michigan have made great progress—in fact far greater progress on a state-wide basis than I have seen in any one other state in the Union. . . . If all states had made as much progress as you have in making available medical as well as hospital coverage on an acceptable economic basis, your prospects of retaining control of medicine

nationally would be far more promising. If you really want to demonstrate your already evidenced capacity for leadership, you will get solidly behind these two organizations (M.M.S., M.H.S.). As we told you last September, it is apparent that the activities of these two organizations are in large measure responsible for the more favorable attitude of Michigan people towards voluntary medicine and hospitalization than is the attitude of the nation as a whole.

"You as a group in your professional pride and enthusiasm are unquestionably more eager to improve the health of this nation than are those who would accomplish it by fiat."

Such is the opinion of John F. Hunt, after making a survey of California and Michigan, and studying the other surveys that have been made locally and nationally. We may well be proud of what we have done thus far. We have demonstrated that nonprofit services can be operated by the profession, and made to work. We have not yet shown sufficient sales genius to cover the whole nation or all of the population in our own state. This is being done in a systematic way, but cautiously, because of possible adverse experiences. But we must cross that stream, and must sell our wares to all our patients and to the profession of the other states. *Nothing would be gained to win in Michigan and lose in all the other states.* No national legislation will affect forty-seven states, and exempt one. Every member of our profession has a friend in some other state that he could interest in this information, and he should do so at once. The time for action is short.

Listen! WJR, Fridays, 7:15 p.m. EWT, MSMS Program!

PROPOSE, NOT OPPOSE

■ We have been against too many things, coming out of Washington and other places, furthering the changing trends as they relate to health services for all the people.

Michigan saw this evolution at its start and has worked consistently and persistently to guide it. True, we have been against many inimical projects: we have opposed Wagner-Murray-Dingell, EMIC, the Delano Plan, the Beveridge Plan. That is all we could do as a small unit of a great profession. Leadership in general was sadly wanting during the years just past.

This is not a criticism of Michigan. Our committees and our thinking men after years of study, trial, and error have evolved a solution to this growing demand for security that is be-

ing expressed by the people worried about adequate health care.

We are now ready to *Propose* instead of *Oppose*.

We believe a National Health Program can be devised which will do several things:

First.—The voluntary prepayment system can be made to work, and to cover as large a proportion of the total population as advisable or needful:—surely indigents, low income groups, and any other groups decided upon.

Second.—Use already established voluntary nonprofit plans for hospital and medical services. This will insure that the administration of the professional and technical services will be done by trained professional people. There are thirty-seven voluntary nonprofit medical and 88 hospital plans in successful operation in forty-two states. That proves sufficient others can be developed, and help should be forthcoming to establish them.

A great bureaucratic system need *not* be set up to live off the rendering of health services to the people.

Third.—Studiously preserve the fundamental American right to free choice of physician, and noninterference with the patient-physician relationship. For wholehearted support this **MUST** be guaranteed.

Fourth.—Medical research to be fostered as a prime essential in insuring the superlative medical care to which our people aspire. This should be generously provided; should be a very major item.

Fifth.—The (Federal or State) government which puts this plan into effect must adopt and maintain the theory of purchasing services and adequately paying for them. Rendering these services is not a function of government.

Sixth.—As a part of this plan and to supervise it, there should be established a Secretary of Health, of Cabinet rank, who is a Doctor of Medicine.

Michigan, out of her experience, is now ready to make this proposal. We hinted at it last month. We believe every State and National Medical Society should join in and push such a plan. We believe in rugged individualism, but the times and the people demand new concepts—a guarantee of adequate health service for all.

The professions have the know-how, the technical knowledge, and successful plans. They

should lead in this movement. We will render the care and can do it much better under our own guidance than under layman administrators.

Listen! WJR, Fridays, 7:15 p.m. EWT, MSMS Program!

CANCER CONTROL IN MICHIGAN

■ During April of each year public interest in the control of cancer is stimulated anew by activities of the Field Army Against Cancer of the American Cancer Society. Since its organization in 1936, the Field Army has been staffed and administered exclusively by women; but this year, for the first time in its history, men are invited to take an active part in its affairs. As both sexes are almost equally susceptible to cancer this broadening of the Field Army's policies will be an advantage to the cancer control program.

Interest in cancer and its control in Michigan has not been confined to the Field Army. In 1930, the first cancer committee was formed in the Michigan State Medical Society and since that time this committee has been among the most active of all the committees of the state society. About six years ago the Michigan State Medical Society and the Michigan Department of Health jointly approved and sponsored a statewide program of lay and medical education in cancer control. During this time the pertinent facts about the nature, causes, diagnosis, treatment and prevention of cancer have been brought to many thousand people in this state.

The Cancer Control Committee of the state medical organization has stimulated local societies to a greater interest in their local cancer problems and means for solving them. There are now in Michigan Hospitals fourteen tumor clinics for the diagnosis and treatment of cancer that have the approval of the Cancer Control Committee.

The work done in these tumor clinics has helped materially to increase the interest of the general public, and especially of some civic organizations, in the cancer control problem and has led the Cancer Control Committee to recommend an expansion of their activities to include the physical examination of the apparently well individual who has been stimulated to want such an examination to detect cancer in early stages. Such examinations will materially aid physicians in caring for their cancer patients; for the find-

ings of these examinations will be reported back to the patient's own physician for his information and use in following out such treatment as may be indicated.

These cancer detection clinics, as they have been designated, have been established in some states, usually under the supervision of Field Army units. Of course they can function only through the support of local physicians who must make the examination. The Field Army's contribution is confined to arousing the interest of people in the clinics, in scheduling patients for examination, and providing the funds needed for their maintenance.

The goal of the American Cancer Society this year is five and one-half million dollars, the greater portion of which is to be used in local communities.

Now, for the first time, it appears that local communities and local medical organizations will be assured of financial resources for carrying on local cancer control projects. The Cancer Control Committee of the Michigan State Medical Society urges local medical societies to support their cancer control programs and to provide the constructive leadership needed to make effective the interest of lay groups and individuals in this matter. It is only by the interest and support of the medical profession that the public will benefit from such programs. By their support physicians will also do much to deprive critics of their accusations that the medical profession will not support health measures designed for the public good.

CANCER COMMITTEE.

ON THE RUN . . .

In distinguishing between jaundice of infective hepatitis and that resulting from homologous serum, persistent vomiting is more common in the former, while arthralgia, urticaria and enlargement of liver and spleen characterize the latter.

Prolonged diarrhea in old people may be caused by achlorhydria.

Clubbing of the fingers has been a repeated observation in ulcerative colitis.

Regenerated liver cells are more resistant to another toxic attack than are normal liver cells.

Long-standing fatty infiltration of the liver usually precedes portal cirrhosis.

—Selected by W. S. REVEÑO, M.D.

TROPICAL DISEASES IN AMERICA AFTER THE WAR

(Continued from Page 386)

conditions are not liable to be spread to this land.

5. Malaria and the dysenteries are the tropical diseases that are most liable to be found here in increasing number.

6. We must all work together to eradicate tropical disease at its source in order to prevent such diseases from assuming dangerous proportions in our own land.

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MICHIGAN MEDICAL SERVICE

(Continued from Page 330)

more for much less than any other insurance plans.

"We are in favor of building a new UAW hospital as a local Detroit enterprise and administering the hospital on a co-operative basis wherein the policy of the institution shall be governed by subscriber members only. . . . A 350-bed hospital would roughly cost \$2,000,000. . . . Auto workers and their families are occupying 2,000 hospital beds, thus only one out of seven persons needing hospitalization could be accommodated in our hospital. The other six would still have to subscribe to hospital service plans.

"And conclusively, this Committee is of the opinion that the most righteous and worthy service our International Officers can render the rank and file members is to stop tinkering with insurance schemes and GET TO WORK ON THE PASSAGE OF SOCIAL LEGISLATION THAT WILL MAKE THE FEDERAL GOVERNMENT RESPONSIBLE FOR THE HEALTH OF THE PEOPLE OF THE NATION."

(Signed) THE COMMITTEE.

Michigan State Medical Society

BUDGETS, 1945 Adopted by The Council in Annual Session. January 27, 1945

GENERAL FUND

INCOME	
3300 Members at \$12 (dues).....	\$39,600.00
Less allocation to JOURNAL (\$150).....	4,950.00
	<u>34,650.00</u>
Interest	1,100.00
Miscellaneous	100.00
TOTAL INCOME	<u>35,850.00</u>
From Reserves	7,941.70
	<u>\$43,791.70</u>

APPROPRIATIONS

Administrative and General

Administrative Salaries	\$ 5,600.00
Salaries: Office—regular	5,400.00
General Counsel	7,500.00
Office Rent and Light	1,360.00
Printing, Stationery, Supplies.....	800.00
Postage	800.00
Insurance and Fidelity Bonds.....	1,636.70
Auditing	650.00
Repairs	50.00
Telephone and Telegraph.....	800.00
Michigan Sales Tax.....	120.00
Payroll Taxes	100.00
Miscellaneous General Expense.....	100.00
	<u>\$24,916.70</u>
Less expenses redistributed to JOURNAL.....	1,800.00
TOTAL ADMINISTRATION AND GENERAL	<u>\$23,116.70</u>

Society Activities

Council Expense	\$ 2,800.00
Delegates to A.M.A.....	400.00
County Secretaries Conference.....	400.00
General Society Travel Expense.....	1,800.00
Officers' Travel Expense.....	1,700.00
Secretary's Letters	300.00
Publication Expense	50.00
Reporting Annual Session.....	175.00
Legal Expense	6,000.00
Woman's Auxiliary—Annual Session.....	200.00
Sundry Society Expenses.....	400.00
	<u>\$14,225.00</u>
Less Annual Session Revenue.....	600.00
TOTAL SOCIETY EXPENSE	<u>\$13,625.00</u>

Committee Expenses

Legislative	\$ 1,000.00
Distribution of Medical Care.....	100.00
Joint Committee on Health Education.....	100.00
Postgraduate Medical Education.....	3,500.00
Preventive Medicine	50.00
Cancer Control	500.00
Child Welfare	50.00
Iodized Salt	50.00
Heart and Degenerative Diseases.....	50.00
Industrial Health and Clinic.....	400.00
Maternal Health	50.00
Mental Hygiene	50.00
Radio	50.00

Venereal Disease Control.....	50.00
Tuberculosis Control	50.00
Public Relations	150.00
Ethics	300.00
Scientific Work	125.00
Procurement and Assignment for M.D.'s.....	200.00
Prelicensure Medical Education.....	50.00
Sundry other committees.....	175.00

TOTAL COMMITTEE EXPENSE..... \$ 7,050.00

GRAND TOTAL

THE JOURNAL

INCOME	
Subscriptions from members.....	\$ 4,950.00
Other subscriptions	100.00
Advertising sales	20,600.00
Reprint sales	750.00
JOURNAL CUTS	75.00

TOTAL JOURNAL INCOME..... \$26,475.00

EXPENSES	
Salaries	\$ 7,200.00
Editor's expense	1,200.00
Printing and mailing (and illus.).....	12,975.00
Cost of reprints and cuts.....	600.00
Discounts and commissions on advertising sales.....	2,300.00
Allocation of administrative and general office expense	1,800.00
Postage	400.00

TOTAL JOURNAL EXPENSE..... \$26,475.00

VETERANS' READJUSTMENT PROGRAM

INCOME	
3,300 members at \$5.00.....	\$16,500.00
EXPENSES	
Salary of Counselor.....	5,000.00
Expenses of Counselor (travel, etc.).....	1,200.00
Salary of office assistant.....	1,800.00
Rent and light.....	780.00
Stationery and supplies, postage, telephone and telegraph	500.00
Postgraduate tuition and expenses.....	5,000.00
Advances and loans.....	2,220.00

TOTAL EXPENSE

PUBLIC EDUCATION ACCOUNT

INCOME	
3,300 members at \$10.00.....	\$33,000.00
EXPENSES	
School of Information.....	3,000.00
Purchase of pamphlets.....	1,500.00
Michigan Health Council.....	7,500.00
Radio and newspaper program.....	20,000.00
Publicizing radio and newspaper programs.....	1,000.00
	<u>33,000.00</u>

REPORT OF AUDITORS FOR 1944

We have examined the balance sheet of the Michigan State Medical Society as of December 29, 1944, and the statements of income and expense and surplus for the period from January 1, 1944, to December 29, 1944, have reviewed the system of internal control and the accounting procedures of the Society and, without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence, by methods and to the extent we deemed appropriate. Our examination was made in accordance with generally accepted auditing standards applicable in the circumstances and included all procedures which we considered necessary.

The Society was organized on September 17, 1910, under the laws of the State of Michigan as a corporation not for pecuniary profit. The charter was extended on November 10, 1941, for a period of thirty years from September 17, 1940. The Society is affiliated with the American Medical Association and it charters county medical societies within the State of Michigan. The purposes of the Society are the promotion of the science and art of medicine, the protection of the public health, and the betterment of the medical profession. In the furtherance of these purposes the Society publishes THE JOURNAL of the MICHIGAN STATE MEDICAL SOCIETY.

MICHIGAN STATE MEDICAL SOCIETY

A summary of the balance sheets at December 29, 1944, follows:

Balance Sheet

ASSETS, DEC. 29, 1944

Cash	\$48,252.95
Accounts receivable, less reserve.....	2,076.97
Securities—at cost	29,528.25
Postgraduate Medical Education Foundation.....	18,210.56
Deferred charges	49.23
	<u>\$98,117.96</u>

LIABILITIES

Accounts payable	\$ 8,020.50
Unearned income	14,632.00
Reserves	31,862.33
Surplus	43,603.13
	<u>\$98,117.96</u>

Income and Expense Statement

A summary of the income and expense statement for the period from January 1, 1944, to December 29, 1944, is presented as follows:

INCOME	
Membership fees	\$36,480.39
Income from THE JOURNAL.....	7,919.39
Interest received	1,100.03
Miscellaneous	101.26
TOTAL INCOME.....	\$45,601.07
EXPENSES	
Administration and general.....	\$22,032.75
Society activities	4,633.79
Committee expenses	3,901.35
TOTAL EXPENSES.....	\$30,587.89
EXCESS OF INCOME OVER EXPENSES.....	\$15,013.18
Other deductions	50.00
NET INCOME	\$14,963.18

Accounts receivable for advertising were analyzed as to month of charge and are shown in comparison with a similar classification at December 31, 1943, as follows:

MONTH OF CHARGE	December 29, 1944 Amount	Per Cent
October, November, and December.....	\$2,129.69	97.83%
July, August, and September.....	41.64	1.91
January to June, inclusive.....	5.64	.26
TOTAL	\$2,176.97	100.00%

Our examination of accounts receivable at December 29, 1944, included tests of the balances by communication with selected debtors. It is our opinion that the reserve in the amount of \$100.00 is sufficient for losses anticipated in collection of the accounts.

The changes in securities during the period were as follows:

Balance at January 1, 1944.....\$32,520.58

ADDITIONS

Securities purchased from William A. Hyland, trustee, at market price as of June 23, 1944: Southern Pacific Company, 4½% bond, maturing March 1, 1977.....	\$ 850.00
Securities purchased from Michigan National Bank at price of issue:	
United States Savings Bonds:	
Series G, 2½%, maturing June 1, 1956	5,000.00
Series G, 2½%, maturing November 1, 1956	8,500.00
Increase in redemption value of United States Savings Bonds acquired in prior years..	221.70
	<u>14,571.70</u>
Balance at December 29, 1944.....	\$47,092.28

Represented by:

Securities held by the Society.....	\$29,528.25
Securities held by the trustee for the Postgraduate Medical Education Foundation.....	17,564.03
Balance at December 29, 1944.....	\$47,092.28

Securities owned at December 29, 1944, have been stated at cost. We inspected the securities and accounted for the income therefrom for the period. At December 29, 1944, aggregate market prices of securities held by the Society were \$1,155.00 in excess of cost, and

aggregate market prices of securities held by the trustee for the Postgraduate Medical Education Foundation were \$182.57 in excess of cost. Details of the securities are shown in a schedule in this report.

The assets held by the trustee for the Postgraduate Medical Education Foundation are shown separately in the balance sheet at December 29, 1944, and the unexpended balance has been reflected in a reserve in the accompanying balance sheet. The income and expense of the Foundation during the period are shown in a statement included in this report.

Biddle Bequests

The Michigan State Medical Society is a legatee under the respective wills of the late Dr. Andrew P. Biddle and Grace W. Biddle, the terms of which direct that the income from these bequests is to be used for "postgraduate work in medicine."

The legacy from Dr. Biddle consists of property, the value of which has been estimated by the trustee for the estate to be \$3,000.00 at December 29, 1944, and life insurance in the amount of \$13,182.12. Insurance proceeds totaling \$8,559.22 were received during the period under review.

The legacy under the will of Grace W. Biddle is subject to a life interest and certain specific cash bequests, and its net value to the Michigan State Medical Society has been estimated by the trustee for the estate to be \$20,000.00 at December 29, 1944.

Only the cash received from these bequests has been included in the accounts of the Michigan State Medical Society.

The Society has continued its policy of waiving payment of dues of members in military or naval service and, in the event the dues were paid for the year of induction, to allow free membership for the balance of the year of discharge. During the period there was little change in the number of members in the services, and the provision made in prior years for the deferment of the income received from these members is sufficient to provide for those now in the services who entered service as currently paid-up members of the Society.

Public Education Account

The budget for 1944 adopted at the January meeting of the Council included a provision for the Public Education Fund with the stipulation that a separate accounting thereof should be made. The budget and the actual receipts and disbursements of the Fund for the period from January 1, 1944, to December 29, 1944, are shown as follows:

Receipts from assessment of members	\$34,000.00	\$34,480.50	\$ 480.50*
Disbursements for expenses..	34,000.00	21,116.73	12,883.27
Balance at December 29, 1944	\$	\$13,363.77	\$13,363.77*

A statement included in this report shows details of the expenses of the Fund for the period. The unexpended balance of the Fund at December 29, 1944, in the amount of \$13,363.77, has been reflected in a reserve in the accompanying balance sheet.

Opinion

In our opinion, the accompanying balance sheet and related statements of income and expense present fairly the position of Michigan State Medical Society at December 29, 1944, and its income and expenses for the period from January 1, 1944, to December 29, 1944, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding period.

ERNST & ERNST,
Certified Public Accountants

January 15, 1945.

MICHIGAN STATE MEDICAL SOCIETY

BALANCE SHEET

December 29, 1944

ASSETS

<i>Cash</i>			
Demand deposits	\$15,246.12		
Office cash fund	6.18		
Savings Deposits	22,967.31		
Time certificates of deposit	\$10,000.00		
Accrued Interest	33.34		
		10,033.34	
			\$48,252.95
<i>Accounts Receivable</i>			
For advertising	\$ 2,176.97		
Less reserve	100.00		
			2,076.97
<i>Securities</i>			
Bonds—at cost			29,528.25
<i>Postgraduate Medical Education Foundation</i>			
Bonds—at cost	\$17,564.03		
Cash	646.53		
			18,210.56
<i>Michigan Medical Service</i>			
Organizational expenditures made by Michigan State Medical Society	\$17,544.45		
Less Reserve	17,544.45		
<i>Deferred Charges</i>			
Expenses in connection with 1945 activities			49.23
			<u>\$98,117.96</u>

LIABILITIES

<i>Accounts Payable</i>			
For current expenses, etc.	\$ 7,541.22		
Exhibitors' duplicate payments	251.50		
Income tax withheld from employees	178.90		
Payroll taxes	48.88		
			\$ 8,020.50
<i>Unearned Income</i>			
Dues for the year 1945	\$ 820.00		
Dues of military members applicable to a future year	13,812.00		
			14,632.00
<i>Reserves</i>			
For deferment of dues paid by military members who have not been reported	\$ 288.00		
For Postgraduate Medical Education Foundation	18,210.56		
For Public Education Fund	13,363.77		
			31,862.33
<i>Surplus</i>			
Balance at January 1, 1944	\$28,639.95		
Net income for the period from January 1, 1944, to December 29, 1944	14,963.18		
			<u>43,603.13</u>
			<u>\$98,117.96</u>

INCOME AND EXPENSE STATEMENT

From January 1, 1944, to December 29, 1944

INCOME			
Membership fees	\$41,692.00		
Less portion allocated to income of THE JOURNAL for subscriptions	5,211.61		
			\$36,480.39
Income from THE JOURNAL—as shown by schedule			7,919.39
Interest:			
On securities	\$ 839.20		
On savings deposits and time certificates of deposit	260.83		
			1,100.03
Miscellaneous			101.26
TOTAL INCOME			<u>\$45,601.07</u>
EXPENSES—as shown by schedule			
Administrative and general	\$22,032.75		
Society activities	4,653.79		
Committee expenses	3,901.35		
			30,587.89
EXCESS OF INCOME OVER EXPENSES			<u>\$15,013.18</u>
OTHER DEDUCTIONS			
Addition to reserve for doubtful accounts			50.00
NET INCOME			<u>\$14,963.18</u>

INCOME AND EXPENSES OF POSTGRADUATE MEDICAL EDUCATION FOUNDATION

From January 1, 1944, to December 29, 1944

Balance at January 1, 1944		\$ 9,356.84
INCOME		
Contributions received:		
From the Estate of Andrew P. Biddle, M.D.	\$ 8,559.22	
From anonymous donor	100.00	
		8,659.22
Interest on securities		267.50
		<u>\$18,283.56</u>
EXPENSES		
Trustee's fees to December 15, 1944	\$ 48.00	
Legal fees	25.00	
		<u>73.00</u>
BALANCE at December 29, 1944		<u>\$18,210.56</u>

MICHIGAN STATE MEDICAL SOCIETY

RECEIPTS AND DISBURSEMENTS OF PUBLIC EDUCATION ACCOUNT

From January 1, 1944, to December 29, 1944

RECEIPTS

From special assessment of the membership.....\$34,480.50

DISBURSEMENTS

Production of the "American Medicine" series of radio broadcasts.....\$10,001.80
 Contribution to the Michigan Health Council.....5,000.00
 Costs of the "School of Information".....3,109.71
 Printing and distributing pamphlets.....2,002.29
 Publicity for radio broadcasts.....935.32
 Miscellaneous67.61

21,116.73

BALANCE at December 29, 1944.....\$13,363.77

INCOME FROM THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

From January 1, 1944, to December 29, 1944

INCOME

Subscriptions from members.....\$ 5,211.61
 Other subscriptions151.50
 Advertising sales22,041.39
 Reprint sales780.96
 JOURNAL cuts79.60
 \$28,265.06

EXPENSES

Editor's salary\$ 1,200.00
 Editor's expense900.00
 Printing and mailing.....12,962.57
 Cost of reprints and cuts.....640.18
 Discounts and commissions on advertising sales....2,592.92
 Allocation of administrative and general expense....1,800.00
 Postage250.00

\$20,345.67

NET INCOME\$ 7,919.39

EXPENSES

From January 1, 1944, to December 29, 1944

ADMINISTRATIVE AND GENERAL

Administrative salaries\$11,600.00
 Office salaries—regular7,152.02
 Office rent and light.....1,341.00
 Printing, stationery, and supplies.....871.42
 Postage626.04
 Insurance and fidelity bonds.....173.28
 Auditing591.25
 Telegraph and telephone.....1,120.69
 Michigan sales tax.....111.79
 Payroll taxes145.72
 Miscellaneous99.54

\$23,832.75

Less expenses redistributed to THE JOURNAL.....1,800.00

\$22,032.75

SOCIETY ACTIVITIES

Council expense\$ 2,782.62
 Delegates to American Medical Association.....246.11
 County secretary's conferences.....391.99
 General society travel expense.....2,294.51
 Officers' travel expense.....1,508.65
 Secretary's letters826.45
 Publication expense64.78
 Reporting annual meeting.....167.10
 National Conference on Medical Service.....198.48
 Woman's Auxiliary—annual meeting.....300.00
 Commissions and discounts—booths.....91.50
 Sundry Society expenses.....350.30

\$ 9,222.49

Less revenue from annual meeting in excess of cost thereof4,568.70

\$4,653.79

COMMITTEE EXPENSES

Legislative\$ 111.58
 Distribution of medical care.....
 Joint committee on health education.....
 Postgraduate medical education.....1,471.19
 Preventive medicine15.10
 Cancer control961.05
 Child welfare14.00
 Iodized salt
 Heart and degenerative diseases.....
 Industrial health286.39
 Maternal health47.37
 Mental hygiene
 Radio
 Venereal disease control.....23.00
 Tuberculosis control
 Public relations123.19
 Ethics461.62
 Scientific work123.87
 Procurement and assignment service for Doctors of Medicine87.84
 Prelicensure medical education.....
 Professional liaison
 Sundry other committees.....175.15

\$3,901.35

TOTAL\$30,587.89

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Michigan's Department of Health

WM. DE KLEINE, M.D., Commissioner, Lansing, Michigan

SYPHILIS FILM

A color film, "Syphilis," which was prepared especially for physicians by the U. S. Public Health Service, is now available to medical societies from the Bureau of Venereal Disease Control, Michigan Department of Health. Reel I deals with diagnosis of early syphilis. A narrator discusses the cases which are pictured. Reel II deals with diagnosis of late and latent syphilis and Reel III with management of syphilis. Showing time is forty-five minutes. In writing for the film more than one possible date for showing should be listed when possible.

MEASLES IMMUNE SERUM

Immune serum globulin (gamma globulin) for the prophylaxis, modification and treatment of measles is now made available for the civilian population by the American Red Cross through state health departments.

The Michigan Department of Health has ordered 9,000 5 c.c. vials of immune serum globulin which should be ready for distribution to physicians and hospitals by April 1.

The Red Cross is bearing the entire cost of processing and distributing immune serum globulin on the policy that "globulin accumulated in excess of the needs of the armed forces should be given back to the American people who made it available through the American Red Cross Blood Donor Service."

Since almost every adult in the United States has had measles, the blood donated for plasma is a rich source of the antimeasles globulin.

The crude serum globulin fraction is derived as a by-product from processing serum albumin under Navy control. It has been declared surplus and assigned by the Navy to the American Red Cross for distribution.

NORMAL SERUM GAMMA GLOBULIN ANTIBODIES (HUMAN) CONCENTRATED (IMMUNE SERUM GLOBULIN)*

1. What is this material?

This preparation is a concentrate containing the antibody globulins derived from pooled normal human plasma collected by the American Red Cross.

2. What is its potency?

Preparations of Gamma Globulin Antibodies are standardized so that the concentration of antibody is twenty-five times that of the plasma pool from which it came. Since each pool is obtained from several thousand donors, variations in titer of measles antibody should be slight. Each preparation is tested for potency in the laboratory by tests for antibodies which can be readily measured. Whenever possible its potency is checked in a series of patients exposed to measles before release for general use.

*Prepared by C. A. Janeway, M.D., Harvard Medical School, Department of Pediatrics, for distribution by the American Red Cross.

3. Stability

This material should be kept in the icebox like other biologicals. The dating period at present is set at one year. It is probable that it will retain its potency for longer periods of time.

4. Indications

At present this material is released *only* for the prevention and modification of measles by passive immunization. Other possible uses are being studied, but insufficient data are available to evaluate its efficacy in these circumstances. Its use in the treatment of measles or the treatment or prophylaxis of other childhood diseases is not recommended at present.

5. Administration and dosage

This material may be administered when indicated to patients who have had a definite exposure to measles in the infectious stage. Its use to prevent or to modify the disease is at the discretion of the physician.

For prevention—A dose of .08-0.1 c.c./lb. body weight should be given as soon after exposure as possible, but will be fairly effective in the first seven days.

For modification—A dose of .02-.025 c.c./lb. body weight should be given on or about the fifth day after first definite exposure.

Method of administration—The globulin is injected *intramuscularly*, preferably in the buttocks. For this, a 20- or 21-gauge needle is most satisfactory. Pull back on plunger of syringe before injection to be sure needle is not in vein, *since globulin as now prepared must not be used intravenously*.

Caution—The globulin is a concentrated protein solution, hence viscous and sticky. Do not fill syringe until prepared to make injection, otherwise syringe may become frozen.

Jaundice—Blood, plasma, and serum have been found on occasion to contain a jaundice-producing agent. Therefore, it is possible that fractions derived from plasma may contain a similar agent. Such jaundice appears two to six months after injection. No jaundice has been attributed to this material so far, but careful records of its use should be kept so that any cases of jaundice occurring two to six months after injection may be traced to the particular lot concerned.

6. Safety

A great many *intramuscular* injections have been given without any serious reactions and with very little local pain in the dosage recommended. Rarely, fever, irritability, or tenderness of the site may follow injection in the first 24 hours.

7. Duration of effect

A single dose will probably protect a child for about three weeks. At the end of that time, if the child is re-exposed and protection is desired, the dose should be repeated.

8. Results of injection

With any biological system, in which the virulence of the virus and the resistance of the host may vary considerably, some variation in results is to be expected. With the small doses used for modification, a few patients will develop typical measles; with the large dose, used for prevention, a certain number will fail to develop any evidence of measles.

Mild measles which results from a satisfactory modification may vary from a disease only slightly milder than the average case to one that exhibits only one or two of the stigmata of measles. Malaise and fever are usually markedly reduced, the catarrhal symptoms slight, and rash may be evanescent and sparse.

SMOOTHAGE

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Metamucil softens the fecal residue, protects intestinal mucosa and exerts a gentle, stimulating, physiologic peristalsis.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Woman's Auxiliary

"FINEST ASSET"

I want you to know that the Woman's Auxiliary to the Michigan State Medical Society is one of the finest assets we have. The members are really getting down to work. They have done some splendid work. Their work, particularly in the past two years, should really be commended by this House. It is really marvelous.

The activity they have aroused and the reading they do! I dare say the officers and the committees of the Woman's Auxiliary are reading a great deal more of our Michigan JOURNAL than most of our men members are. They are following the headlines of the newspapers. They are extremely interested in politics. The old saying, "The way to win a man's heart is to fill his stomach," is not true any more, but women are certainly helping to win over the politicians.

Therefore, I think it behooves us to give the Woman's Auxiliary more consideration. Particularly, I would ask the Council to help them financially when necessary. Let us turn in and help them.—F. E. REEDER, M.D., *Chairman*, MSMS Advisory Committee to Woman's Auxiliary. Before House of Delegates, Grand Rapids, Sept. 25, 1944.

BAY COUNTY

The Woman's Auxiliary to the Bay County Medical Society held its February meeting at the home of Mrs. M. R. Slattery, Wednesday, February 14.

Following dessert, C. L. Hess, M.D., showed a group of slides of pictures taken in Africa and Italy by Lieut. Col. F. Pitkin Hustad, formerly of Bay City. Mrs. C. L. Hess, president, conducted the business meeting, and announced work on the Crippled Children's Seal sale would start at the March meeting. There were thirty-two members present.

WAYNE COUNTY

The regular meeting of the Woman's Auxiliary to the Wayne County Medical Society was held March 9 at the Club House with the program in charge of the Public Relations Committee. The speaker was Major General G. B. Chisholm, C.B.E., M.C., E.D., Director General of Medical Service in the Canadian Army. His subject was "Rehabilitation of Returned Soldiers." Tea was served following the program.

* * *

Mrs. Homer Ramsdell, State *Bulletin* chairman, reports 112 subscriptions to *The Bulletin* as of February 26, 1945.

COUNTY PRESIDENTS 1944-1945

- Bay*—Mrs. C. L. Hess, 406 Hill Street, Bay City.
Delta-Schoolcraft—Mrs. D. H. Boyce, 1401 First Avenue, Escanaba.
Genesee—Mrs. D. B. Wright, 403 W. Court Street, Flint.
Grand Traverse—Mrs. Paul H. Wilcox, 502 W. 8th Street, Traverse City.
Gratiot-Isabella-Clare—Mrs. R. L. Waggoner, St. Louis.
Houghton-Baraga-Keweenaw—Mrs. P. S. Sloan, 214 Clark Street, Houghton.
Ingham—Mrs. Dana Snell, 1230 S. Genesee Drive, Lansing.
Ionia-Montcalm—Mrs. V. L. VanDuzen, Belding.
Jackson—Mrs. George D. Woodward, 768 Oakridge Drive, Jackson.
Kalamazoo—Mrs. Homer Stryker, 448 W. Inkster Avenue, Kalamazoo 35.
Kent—Mrs. Merrill Wells, 3346 Coit N. E., Grand Rapids.
Manistee—Mrs. Homer A. Ramsdell, 514 Oak Street, Manistee.
Midland—Mrs. Charles L. MacCallum, Sugnet Road, Midland.
Newaygo—Mrs. Oscar D. Stryker, 115 Division Avenue, Fremont.
Oakland—Mrs. A. S. Kimball, 7350 Cooley Lake Road, Pontiac, 11.
Ottawa—Mrs. Chester Van Appledorn, Holland.
St. Clair—Mrs. Clyde Martin, Port Huron.
St. Joseph—Mrs. R. J. Fortner, 219 East, Three Rivers.
Saginaw—Mrs. Frederick Pietz, 2139 Gratiot Street, Saginaw.
Van Buren—Mrs. Arthur H. Steele, 723 N. Kalamazoo Street, Paw Paw.
Washtenaw—Mrs. Leonard E. Himler, 1615 Wells Street, Ann Arbor.
Wayne—Mrs. W. L. Sherman, 201 E. Kirby Avenue, Detroit 2.
Wexford-Missaukee-Osceola—Mrs. H. J. Masselink, McBain.

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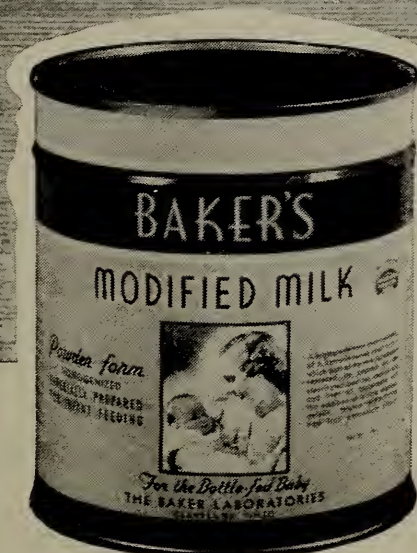
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A Highly Nutritious Food for Infants...

from birth throughout the bottle feeding period

- *Baker's Modified Milk is a food for infants that may be used either entirely in place of mother's milk or complementary to breast feeding . . .*
- *A food that is well tolerated by both premature and full-term infants . . .*
- *A food that does not require complicated directions and is easily prepared for feeding . . .*
- *A food that is advertised only to the medical profession.*

THESE are reasons why Baker's Modified Milk is so steadily gaining wide prescription.

Applicable to practically all infant feeding cases during the entire bottle-feeding period, Baker's is a time-saver for today's busy physician. And mothers like to feed Baker's because it is convenient and economical to use. With Baker's there's little chance for error, for there's

only one thing to do—dilute to prescribed strength with water, previously boiled.

The mother enjoys a well-nourished and happy baby, because Baker's is well-supplied with the nutritive elements for normal growth and fortified with seven dietary essentials, including liberal protein content (60% more than human milk). Write for samples and complete information.

Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B₁ and D. Not less than 400 units of vitamin D per quart.



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What's What

Honors

Phil H. Quick, M.D., of Olivet, an Emeritus Member of the Michigan State Medical Society, was recently honored by the citizens of Eaton County. Dr. Quick is the oldest physician in his county both in age and in years of service.

* * *

R. S. Morrish, M.D., Flint, Councilor of the Michigan State Medical Society, was re-elected Chairman of the Genesee County Red Cross Chapter for the seventh consecutive year. Congratulations, Dr. Morrish!

* * *

O. E. Madison, Associate Professor of Chemistry at Wayne University, Detroit, has been re-elected President of the American Association of Basic Science Boards. Dr. Madison has been a member of the Michigan Board of Examiners in the Basic Sciences for a number of years.

* * *

Meetings

The Annual Ingham County Clinic will be held at the Olds Hotel, Lansing, on Thursday, May 3, 1945, beginning at 1:30 p.m.

Among the guest speakers will be L. A. Buie, M.D., Rochester, Minnesota, on "Rectal Diseases"; Frank N.

1945 DUES ARE DUE

April 1 is the deadline date for the payment of MSMS dues and assessments. The annual dues are \$12.00, and the assessments levied by the 1944 House of Delegates are \$15.00, making a total of \$27.00.

Only members can be sent future issues of the MSMS JOURNAL. This action is necessary to comply with postal regulations.

Send your check today to the Secretary of your County Medical Society for your County and State Medical Society dues.

Allen, M.D., Boston, on "Fatigue"; and Irving Page, M.D., Cleveland, on "Hypertension."

Dinner will be served at the Olds Hotel at 6:30 p.m.

All members of the Michigan State Medical Society are cordially invited to this excellent one-day clinic.

* * *

The Wartime Graduate Medical Meetings Committee sponsored four weekly staff conferences during March at Percy Jones General and Convalescent Hospital, Battle Creek. F. D. Johnston, M.D., Ann Arbor, spoke March 5 on "Cardiac Arrhythmias"; the physical therapy section presented the program of March 12;

(Continued on Page 402)

YOU WRITE THE *Prescription* WE FILL IT . . .

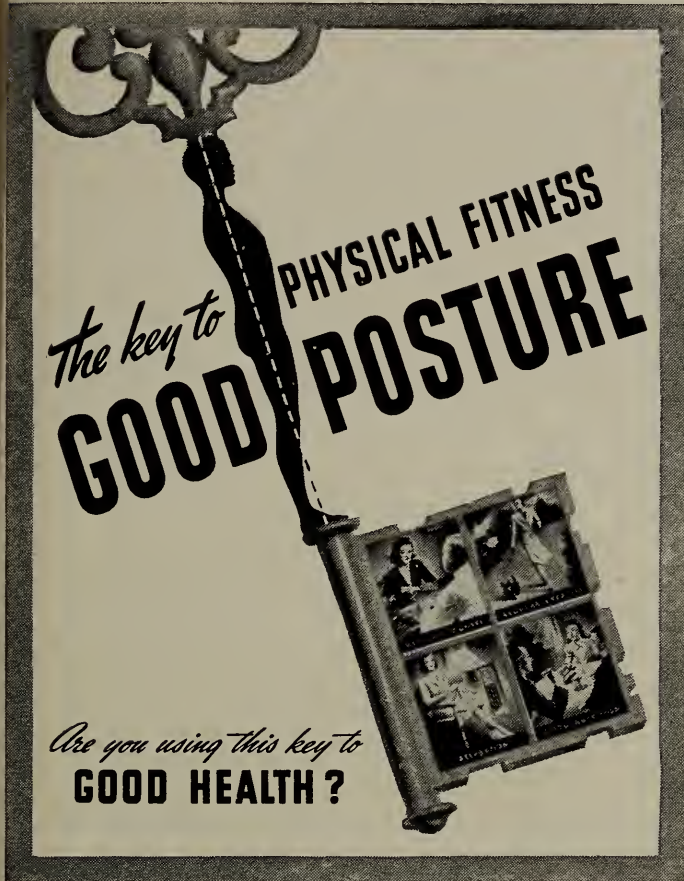
Whenever Dairy Products are indicated in the diet—remember Borden's—Distributors of Fluid Milk, Cream and other Dairy Products.

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NATIONAL POSTURE WEEK



TWO OF A SERIES of educational posters in full color telling the story of Good Posture as one of the elements in Good Health and Physical Fitness. The Poster on the left broadens the theme to stress the importance of medical counsel, sound nutrition, relaxation and sensible exercise.

IN ITS SEVENTH YEAR, National Posture Week continues its sound and ethical program of focusing the attention of the country on the significance of Good Posture to good health and physical fitness. As the years go on, it is becoming evident that the special events of National Posture Week and the year-round program have encouraged many suffering from poor body mechanics to seek professional counsel.

While the public will be reached through every popular channel of public information, emphasis is again being placed on the distribution of authoritative literature to schools, colleges, medical and gov-

ernment bodies, industrial, professional and civic public health groups.

Physicians, educators and lay groups in the field of public health have shown in practical cooperation and voluminous correspondence that they approve the content and methods of National Posture Week and its year-round physical fitness program. It is our hope that we will continue to merit this support in this year of Victory and during the post-war years of adjustment which will present so many problems to those charged with maintaining the health of the nation.

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Free:

These two illustrated 16-page booklets on Posture, prepared especially for physicians to give their patients. "The Human Back . . . Its Relationship to Posture and Health" and "Blue Prints for Body Balance". Write on your professional letterhead, stating quantity of each desired . . . to

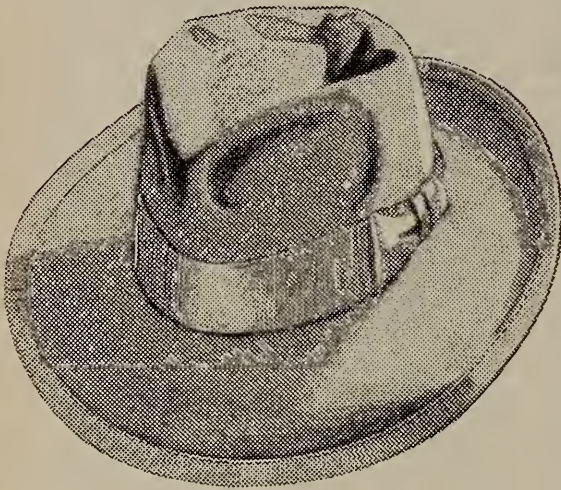
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*Another
Distinguished
Whaling Hat*



The "Strand"—with distinctive
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Meetings

(Continued from page 400)

E. L. Tuohy, M.D., of Duluth, Minnesota, spoke on "Laboratory Techniques in Differentiating Medical and Surgical Approaches in Regurgitational Jaundice" on March 19; J. S. Lundy, M.D., of Rochester, Minnesota, spoke on "Anesthesia" on March 26.

All members of the Michigan State Medical Society are invited to the weekly conferences at Percy Jones Hospital.

* * *

The St. Clair County Medical Society is sponsoring a postgraduate day on Friday, May 11, beginning at 10:00 a.m. The meeting will be held at the St. Clair Inn, St. Clair, Michigan. Among the guest speakers will be Samuel F. Marshall, M.D., and Samuel A. Wilkinson, M.D., both of Leahy Clinic, Boston. Dr. Marshall will speak on a surgical subject and Dr. Wilkinson will lead a round table on some phase of internal medicine. Luncheon and dinner will be served at the St. Clair Inn.

All members of the Michigan State Medical Society are cordially invited to the St. Clair County Medical Society Clinic Day.

* * *

St. Mary's Hospital, Detroit, will hold its centennial celebration on Thursday, May 17.

Arturo Castiglioni, M.D., Research Professor at Yale, Cambridge, Massachusetts, will speak at the dinner meeting, Statler Hotel, Detroit, on "Medical History."

Speakers on the morning program include: Russell L. Cecil, M.D., New York University, New York, on "Modern Conceptions of Arthritis and Its Management"; Emil Novak, M.D., Baltimore, Maryland, on "Functional Tumors of the Ovary"; and Alexander Brunschwig, M.D., University of Chicago, Chicago, Illinois, on "The Extension of Radical Surgery in the Treatment of Advanced Abdominal Carcinoma."

Frederick A. Collier, M.D., of Ann Arbor will lead a round-table discussion on "Gall-Bladder Disease" in the afternoon. The discussants will be Drs. Novak, Cecil, Brunschwig, Hugo A. Freund, M.D., Detroit, and C. S. Kennedy, M.D., Detroit.

Members of the Michigan State Medical Society are cordially invited to attend the scientific program of St. Mary's Hospital centennial celebration.

* * *

Socio-Economic

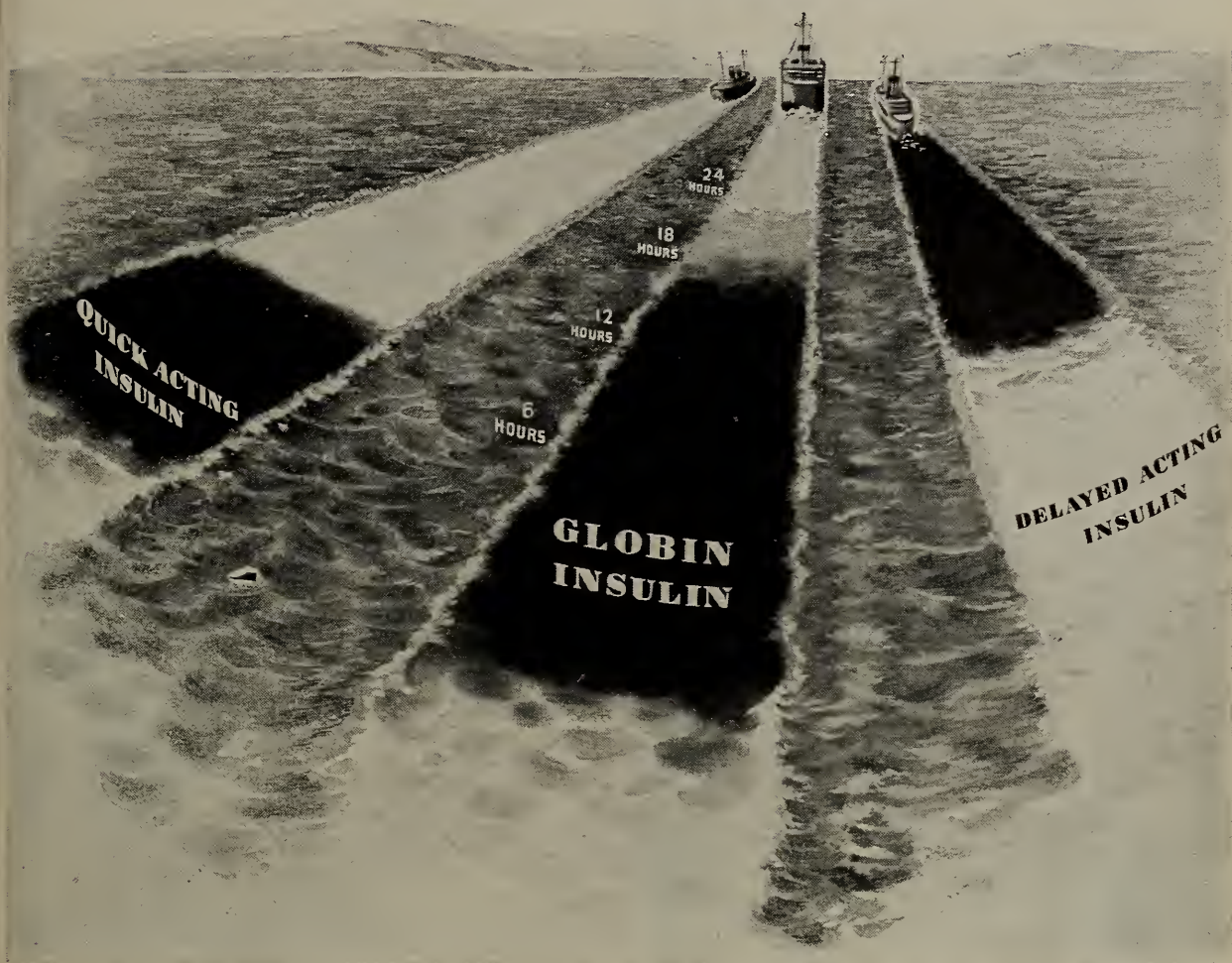
State health insurance proposal in Massachusetts: A special commission, representing all interests, studied the problem for the legislature of Massachusetts during 1944. Their report was unfavorable to any state action—based upon statistical evidence that at least two-thirds of workers in Massachusetts are receiving payments in event of illness and that, through the efforts of private enterprise, the number is increasing very rapidly.

* * *

The Rhode Island system of cash sickness benefits has already begun to show every indication of becoming much more costly than was anticipated. Evidence

(Continued on Page 404)

The MIDDLE COURSE of diabetes control



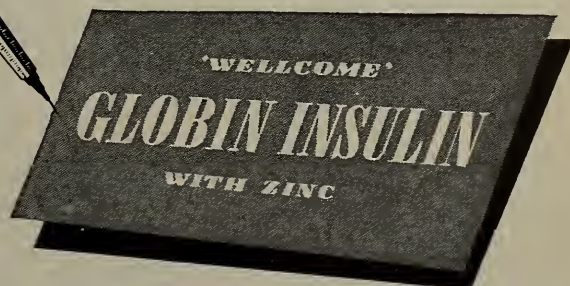
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WHAT'S WHAT

Socio-Economic

(Continued from Page 402)

of malingering on a fairly large scale is quite obvious. Reserves are being steadily drained away and the administrative costs are becoming a serious problem. This experience, in time of high employment, bodes ill for that which may be expected when employment is at a lower rate.

* * *

The California compulsory health insurance proposal. The California Medical Association has gone on record, at a special meeting of its House of Delegates, as being opposed to Governor Warren's compulsory health insurance plan or to any other compulsory health insurance plans so far presented to it. The CMA has introduced a bill into the Legislature calling for the reduction of payroll taxes for employees who provide for their own medical or hospital care through voluntary programs (California is one of the four states in the union which charge the employee a 1 per cent tax for unemployment benefit purposes). This bill would also provide that an employer could make payroll deductions for his entire group of employees for the payment of dues or premiums for voluntary health care plans, except where a written objection is filed by the employee. The bill would further provide that employees not covered by voluntary health care plans would be entitled to draw regular unemployment benefits during periods of unemployment caused by nonindustrial accidents or illness. The CMA proposal encourages voluntary plans, such as California Physicians Service, Blue Cross, and reputable insurance company policies.

* * *

The Social Security Referendum of the Chamber of Commerce of the United States shows that 96.5 per cent of the chambers of commerce and trade associations which replied were of the opinion that there should be an avoidance of a system of socialized medicine under which all the medical personnel become government employees and the free choice of doctor by the patient and of the patient is impaired. A total of 2,299 answered in the affirmative and 82 answered in the negative.

Ninety-four answered in favor of voluntary group effort to provide more adequate medical services for all the people; 90.8 per cent felt that employers who have not done so should explore the possibility of providing for their employees some protection against non-industrial or nonoccupational disabilities and sickness.

* * *

Senator Pepper: "I want the Senate to know that we are not out for socialized medicine. We are not out to break down the standards of the profession. We do not have any panacea. We are merely trying what we may properly do to bring a greater degree of health to the nation."

* * *

"A Delicate Plant" is the title of an excellent article on the extraordinary growth and success of Michigan Medical Service, which appeared in the *Detroit Medical News* of March 5. The title is a quotation

(Continued on Page 406)



THE Birtcher Hyfrecator grows and grows in acceptance. Thousands of physicians acclaim it to be the "cleverest little device they have seen in all their years of practice." General Practitioners, E.E.N. & T. Specialists, Dermatologists, Proctologists, Gynecologists and Urologists have found many daily uses in which the Hyfrecator excels. More than 33 proven Hyfrecation technics enables the doctor, without special training, to treat more patients . . . with quicker and surer results . . . and far less discomfort.

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Socio-Economic

(Continued from Page 404)

from Dr. Garfield of the Kaiser Industrial Medical Service Plan who dubbed the largest and most successful voluntary prepayment program in the world "a delicate plant."

* * *

Good Reading

"*Pennies Pay the Doctor*" is an article which every doctor of medicine should show to his patients. This excellent article in *Hygeia*, The Health Magazine, February, 1945, explains what has been done by Michigan Medical Service. Reprints may be obtained by writing the Michigan Health Council, Washington Blvd. Bldg., Detroit 26, or direct to *Hygeia*, The Health Magazine, 535 North Dearborn St., Chicago 10.

* * *

"*Social Security—past—present—future?*" A newly-published book by Gerhard Hirshfeld, Director of the Research Council for Economic Security. The eleven chapters of Mr. Hirshfeld's book are interesting and highly informative. His approach is new and opens up complete new avenues of thought. The author feels that study of the centralized systems in use abroad should yield information as to how similar systems should be applied in this country, avoiding centralization and compulsion.

Published by the American Tax Payers' Association, Washington, D. C., price \$1.00. It can be secured through the Insurance Economics Society of America, 176 W. Adams St., Chicago 10.

* * *

Activity

The Calhoun County Medical Society has adopted a unique plan of administration. An Active Policy committee was elected and empowered to act on measures coming before the county group.

Joseph E. Rosenfield, M.D., Battle Creek, was made chairman and he has charge of all publicity. George A. Zindler, M.D., Battle Creek, is secretary and he has charge of co-ordinating all Postgraduate and Post-war educational problems in all hospitals for returning military members, including the raising of funds for the committee program. Carl G. Wencke, M.D., Battle Creek, will have charge of Political Medicine. Russell L. Mustard, M.D., Battle Creek, is to develop plans for a central office and executive secretary and a central telephone agency to guarantee that all calls for medical care shall be responded to promptly. D. L. Finch, M.D., Battle Creek, has charge of the rehabilitation problems of members returning from war service. He also is to keep in communication with them, sending bulletins and other useful information. A. T. Hafford, M.D., of Albion, is to co-ordinate all of these activities in the areas outside Battle Creek.

Battle Creek is especially favored with good hospitals having teaching possibilities: Leila, Community, County T.B., American Legion, Kimball Contagious, B. C. Sanitarium, Veterans Bureau No. 100, and Percy Jones.

(Continued on Page 408)

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Activity

(Continued from Page 406)

"*American Medicine*," the Michigan State Medical Society radio program over Station WJR, Detroit, features a member of the Michigan medical profession every Friday, 7:15 p.m., EWT.

To date, the medical speakers have been C. L. Candler, M.D., Detroit, Chairman of the MSMS Special Committee on Radio, who presented the introductory statement concerning the radio program of the State Medical Society on Feb. 16; Secretary L. Fernald Foster, M.D., Bay City, spoke on "Purposes of the Michigan State Medical Society" on Feb. 23; Treasurer Wm. A. Hyland, M.D., Grand Rapids, spoke on "Michigan Medical Service" on March 2; Councilor O. D. Stryker, M.D., of Fremont spoke on "Medical Men in Service" on March 9; Editor and Councilor Wilfrid Haughey, M.D., Battle Creek, spoke on "Psychiatry After the War" on March 16; Council Chairman E. F. Sladek, M.D., Traverse City, spoke on "Voluntary Programs of Medical Care" on March 23; Councilor R. S. Morrish, M.D., Flint, spoke on "Health Education of the Public" on March 30, and Speaker P. L. Ledwidge, M.D., Detroit, spoke on "Protection Against Major Hazards of Illness" on April 6.

The MSMS radio program will continue through June.

* * *

Not Canceled.—The art contest sponsored by Mead Johnson & Company on the subject of "Courage and Devotion Beyond the Call of Duty" (on the part of physicians) has *not* been canceled or postponed.

The closing date remains May 27, 1946.

There will be no annual exhibit *this year* of the American Physicians Art Association, due to the cancellation of the American Medical Association meeting which had been scheduled to take place in Philadelphia, June 18-22, 1945.

For full details regarding the \$34,000 prizes and the "Courage and Devotion" contest, write Dr. Francis H. Redewill, Secy., A.P.A. Assn., Flood Bldg., San Francisco, Calif., or Mead Johnson & Co., Evansville, Ind.

* * *

A Tip

Doctor, when you take care of an afflicted or crippled child who is a ward of the State, be sure to have your secretary make a duplicate bill. One copy should be sent to the hospital in which the medical or surgical work was performed, and the other copy should be sent direct to the Michigan Crippled Children Commission, 458 Hollister Bldg., Lansing, Michigan.

A number of instances where doctors' bills were far below the fee listed in the schedule of the MCCC indicates that the office assistant in the hospital billed the Commission for a lesser figure. The Commission will pay only what the doctor bills the Commission through the hospital. Therefore, send your bill through the hospital, as well as direct to the Commission.

Be sure to indicate the case number on your bill.

(Continued on Page 410)



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Talks

A. C. Furstenberg, M.D., Ann Arbor, addressed the Genesee County Medical Society on February 27. His subject was "Postwar Medical Factors."

* * *

Wilfrid Haughey, M.D., Editor of *THE JOURNAL* of the Michigan State Medical Society, spoke to the Personnel Club of Battle Creek on February 22. His subject was "Compulsory Health Insurance vs. Voluntary Group Medical Care Plan."

* * *

R. L. Novy, M.D., Detroit, President of Michigan Medical Service, spoke on "Current Political and Social Trends of Medicine" at the meeting of the Calhoun County Medical Society, March 6, in Battle Creek. The meeting was attended by the Woman's Auxiliary and representatives of local business, industry and labor, the legal, dental and pharmaceutical professions and members of city government—about 200 in all.

* * *

Dallas B. Phemister, M.D., University of Chicago, led a seminar on "Diseases of Bone" at a meeting of the Michigan Pathological Society, held at Harper Hospital, Detroit, Saturday afternoon and evening, February 17. Members of the Michigan Orthopaedic Society and of the Detroit Roentgen Ray and Radium Society were guests of the Michigan Pathological Society. One hundred and twelve physicians attended.

* * *

Paul D. Bagwell, Professor of Speech and Head of the Department, Michigan State College, addressed the St. John's Rotary Club on Tuesday, March 13. His subject was "What Is Contained in the Proposed Amendment to the Constitution of the State of Michigan."

* * *

Councilor A. B. Smith, M.D., Grand Rapids, addressed the Woman's Auxiliary to the Kent County Medical Society on March 14. His subject was "How Michigan Medical Service Helps Solve the Problem of Distribution of Medical Care." Dr. Smith also addressed a combined meeting of the Ottawa and Allegan County Medical Societies on March 23, on the subject "Medical Economics Today."

* * *

Public Health

Progress in the Art of Saving Human Life.—Extract of talk by Congressman Roy O. Woodruff of Bay City, Michigan, in the U. S. House of Representatives, January 6, 1945:

"The purpose of vivisection is to give to the surgeons of the world the opportunities for experimentation from which much of the progress that has been made in surgery down the years has resulted. Obviously there is one purpose and one purpose only in this activity, and that is to secure knowledge which will enable the

(Continued on Page 412)



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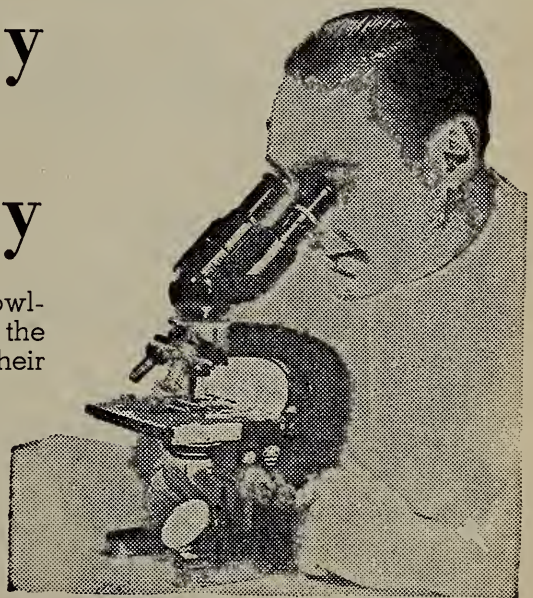
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Public Health

(Continued from Page 410)

scientists to save human life. If experiments were not made on the lower animals, they would necessarily have to be made on human beings. Obviously the former is desirable. . . . The whole structure of medicine and surgery, and the measures now being employed in our armed services, and generally throughout the country, which are so successful in saving the lives of hundreds of thousands of our soldiers and sailors and the public generally, are recorded in observations and information made possible only by utilization of the lower animals. There are millions of people alive today, who a long time ago would have passed on had it not been for the information our scientists have secured through the medium of vivisection. I feel certain if all our people could know of the benefits which in the past have come to us in this way they would realize that the practice of vivisection cannot be stopped without jeopardizing the lives of future generations."

* * *

Immune serum globulin for the prevention and modification of measles is now being distributed for civilian use by the American Red Cross. The expense of processing and distributing the material is being met by the Red Cross.

The immune serum globulin will be supplied by the American Red Cross without charge to state and territorial health departments or local health departments. They, in turn, will distribute it without charge to physicians, hospitals, and clinics for administration in accordance with established standards and without any charge to the patient for the immune globulin.

* * *

Marriage of Persons With Early Syphilis.—Special medical certificate for marriage license will be issued to persons receiving intensive treatment for early syphilis only after completion of at least a year of satisfactory posttreatment progress. In the light of experience, the previously required period of six months of satisfactory posttreatment progress appears to be too short.

This interval is lengthened to one year upon the advice of the Venereal Disease Control Committee of the Michigan State Medical Society.

* * *

Diphtheria Is Going Up.—Attention is called to the fact that the number of cases of diphtheria in Michigan continues to increase. Health departments are urged to stimulate diphtheria prevention in every way possible. Please submit diphtheria epidemiological case histories promptly, and be sure to indicate whether or not the case has been previously immunized against diphtheria, the product used, the age when immunized, and the number of doses given.

The following immunization schedule is now recommended as an absolute minimum:

1 dose of alum precipitated toxoid at 9 months.

1 dose of alum precipitated toxoid at 10 months,

and a stimulating or booster dose at age 5 or 6 years.

—Mich. Dept. of Health.

(Continued on Page 414)



WE doubt if our Government will reward housewives with an "E" for wartime efficiency; so, we're conferring our own "E" award upon you Detroit housewives whom we are proud to serve.

Your whole-hearted acceptance of rationing regulations has been inspiring. Your cooperation in times of shortages has averted serious food problems.

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Congress

Chiropractors.—Congressman Tolan of California has introduced H.R. 610 into the federal Congress, which would permit chiropractors to treat federal employes under the Federal Compensation Act. This measure has been referred to the Judiciary Committee of the House of Representatives, of which Earl C. Michener of Adrian, Michigan, is a member. Write Congressman Michener expressing your opposition to this measure which would provide for a form of healing care for government employes which is not recognized by the Army and Navy.

* * *

The Hill-Burton Bill (S. 191) providing for hospital construction with federal grants to states and totaling \$505,000,000, is now being heard before the U. S. Senate Committee on Education and Labor. No opposition to this proposed legislation has appeared.

* * *

Future Supply of Doctors.—Senator Allen J. Ellender of Louisiana introduced S. 637 into the Federal Congress on February 26. This bill includes provisions for the deferment of adequate numbers of premedical students for a period of two years and further provides for the deferment of such numbers of medical students as will be sufficient to supplement civilian sources of students for the maintenance of full classes.

The bill also calls for the return to medical and pre-medical studies of qualified members of the armed forces who have honorably served for a year in the military forces.

The bill has been referred to the Committee on Military Affairs of the Senate.

* * *

Miscellaneous

EMIC Program

During the nearly two years that our committees were negotiating with the Children's Bureau of the Department of Labor regarding the EMIC program, we invariably ran into the reply that the administration of the EMIC program was set up as ordered by Congress and could not be modified. As a matter of fact, the Act of Congress says: ". . . to provide, in addition to similar services otherwise available, medical, nursing and hospital, maternity and infant care for wives and infants of enlisted men of the fourth, fifth, sixth, and seventh grades in the armed forces of the United States, under allotments by the Secretary of Labor and plans developed and administered by State Health Agencies and approved by the Chief of the Children's Bureau . . ."

Nearly all of the states offered plans for this program. These were turned down and the Children's Bureau provided plans which the states had to approve if they got the money.

(Continued on Page 416)

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JAEGER, A. S.
Jl. Indiana State Med. Soc.
37; 117, 1944

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ROBERTS, H. K. et al.
J.A.M.A. 123:261: 1943

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EMIC Program

(Continued from Page 414)

We are reliably informed that Labor plans to introduce "State Health Insurance Bills" in possibly eight states, and that Michigan and California have been chosen as "testing grounds."—Editorial, *Indiana State Medical Journal*, February, 1945.

* * *

Whole Blood Quota Raised

In his talk on the Army Hour broadcast over the National Broadcasting Company Network, Major General Paul R. Hawley, Chief Surgeon of the European Theater of Operations, said that the pre-invasion estimate of blood transfusions of one pint for every five wounded men was too low. "Battle experience," he said, "has shown that we must have one pint for every two casualties."

Five special centers have been set up on the East Coast and three on the West Coast where "O" type blood is collected and flown daily to the theaters of operations.

* * *

Radio Broadcasts

Mr. T. E. Laubscher, owner of the Apothecary Shop, Lansing, has started a series of 26 radio broadcasts on Sundays at 4:15 p.m. over Station WJIM. The programs will be song and story giving the history, accomplishments, and aims of the medical profession, also blasting the socialized compulsory programs emanating from Washington.

Such a program sponsored by an ethical drug store,

not a variety store might well be emulated by other similar stores throughout the state.

* * *

Adequate Pay for Indigent Care

Oakland County spent \$250,000 for the care of the indigent during the last year's available report, of which only \$4,000 went to the doctors. This emphasizes the fact that medical care is compensated at cost only, while food, clothing, shelter are paid for at standard rates. The Executive Committee of the Council at the last meeting took a very forward step. It passed a resolution abrogating previous agreements, and certifying to the belief that medical services should be compensated at an ethical rate, rather than cost or loss. The medical man is as worthy of his livelihood as is the grocer, the shoe dealer, or the social worker.

* * *

Receives Air Medal

Captain Harold A. Timreck, Gladwin County physician, received the Air Medal for "meritorious achievement" while participating in aerial combat. We recently reported that Captain Timreck won the "Soldier's Medal" for heroism in helping to remove wounded airmen from a burning plane. Captain Timreck belongs to the 486th Bomb Group, cited by the President for its England to Africa Shuttle Bombing of the Messerschmitt plants at Regensburg, Germany.

* * *

Colonel Slevin Returns

Col. John G. Slevin, F.A.C.S., the first physician in Michigan to volunteer for army service returned to

(Continued on Page 418)

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Adequate Pay for Indigent Care

(Continued from Page 416)

private practice in Detroit in March. His release is the result of a recently announced War Department policy to return to private practice certain high-ranking medical officers of civilian components.

MICHIGAN'S STATE MEDICINE PROPOSALS

S.B. 362 and H.B. 423 were introduced into the Michigan Legislature in April, 1945. Called the "people's health act," these identical bills provide for a scheme of compulsory state health insurance. As gathered from the declaration of policy appearing in section 2 of the bills, the measures are based on the false premise that the only way in which the public is to obtain the benefit of medical science is through collectivism and government control. The operation of the scheme is to be in the hands of political appointees, a very few if any of whom are to be doctors of medicine. Unless one is to assume that this is the ideal approach to the better distribution of medical care, there seems little advantage in discussing the minute details of administration of this monstrosity.

In a recent editorial by Malcolm W. Bingay, entitled "Galloping Reforms," pertinent reference is made to the question of state medicine. Shortly before the introduction of these two bills, Mr. Bingay wrote as follows:

"Now the battle is on to take over the practice of medicine. There are many faults in the present medical setup as all good doctors know. But as we lost the golden eggs of temperance by killing the goose, are we not in danger of setting back medicine by trying to force reforms in the hands of people who know nothing about the subject or know too much that isn't so? One would think, to hear the advocates of government controlled medicine, that no advance has been made in the healing arts under our present system. * * * "The medical profession has made strides equal to those of any other group and vastly superior to any development in the science of government. Will that advance continue if Congressman Joe Doakes, in return for a political favor, can get his uncle Willie—who used to be the Indian in a patent medicine show—an important job in the bureaucracy which is to regiment the physician?"

Up to February 19, this year, 6,027 soldiers of the United States had lost at least one arm or leg in World War II. Of these 331 have lost two limbs. There have been two with loss of three limbs, and no cases of loss of all four.

* * *

Federal aid to states had increased from five million dollars in 1915 to 786 million dollars in 1942. During the same approximate period, state aid to local governments increased from 119 million dollars in 1912 to 1,789 millions in 1942.

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OBSTETRICS—Two-week Intensive Course April 9, June 4.

ANESTHESIA—Two-week Course Regional in Intravenous and Caudal Anesthesia.

ROENTGENOLOGY—Courses in X-Ray Interpretation, Fluoroscopy, Deep X-Ray Therapy every week.

UROLOGY—Two-week Course and One-month Course every two weeks.

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

THE AVITAMINOSES, The Chemical, Clinical and Pathological Aspects of the Vitamin Deficiency Diseases, By Walter H. Eddy, Ph.D., Emeritus Professor of Physiological Chemistry, Teachers College Columbia University, and Gilbert Dalldorf, M.D., Pathologist of the Grasslands and Northern Westchester Hospitals, Westchester County, New York. Third Edition. Baltimore: The Williams & Wilkins Company, 1944. Price \$4.50.

Part I of this book is an introduction to the vitamins, their chemical structure, behavior, nature and functions. Vitamin A, Thiamine, Riboflavin, Niacin, Pyridoxine, "Bios" Nutriles, D, C, E, K—all are given a small introductory chapter. Part II takes up the deficiency diseased dependent upon the vitamins, also infectious diseases, medical care and nutritional failure. This is extensive. Part III is assay methods, laboratory tests, bibliography, et cetera. This book is of increasing value as our knowledge and lack of knowledge of the vitamins becomes more intense.

* * *

THE MIDWEST PIONEER, His Ills, Cures and Doctors. By Madge E. Pickard, and R. Carlyle Buley, Crawfordsville, Indiana; R. E. Banta, 1945. Price \$5.00.

The authors are of the staff of the Indiana University library, and in their work of middle western history have accumulated a vast amount of facts about the pioneer in this region, and his ill and methods of care.



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*"Don't go to Michigan, that land of ills;
The word means ague, fever and chills."*

There were many books for family guidance, dozens of which are described. The origin of the medical societies is described. Local doctors who did big things such as the first cataract, the first ovariectomy, the first anesthetic—all these and many more are entertainingly described. The fights of the eclectics, the homeopaths, hydropaths, phrenologists, mesmerists, and the allopaths, a name applied by these various cults to the regulars to bring them into a semblance of sectarianism, are given space. Forms of practice, materia medica are described. This book is unique, a great material source, and most interesting from a historical viewpoint. It is as yet a limited edition, but a library piece of choice.

* * *

THE MARIHUANA PROBLEM in the City of New York, Sociological, Medical, Psychological and Pharmacological Studies. By the Mayor's Committee on Marihuana. Lancaster, Pennsylvania: The Jaques Cattell Press, 1944. Price \$2.50.

This study was undertaken at the request of Mayor La Guardia, and at the suggestion of the New York Academy of Medicine. The committee consisted of six-



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teen doctors of medicine and two doctors of philosophy. The study has been complete and searching, covering the sociologic, clinical, and pharmacological aspects. There are many tables of results, studies of the action of the drug, its end results, and the prevalence of its use in New York. The problem turned out to be not so alarming in New York as had at first been thought, but it was alarming and dangerous in some other places, and a warning was sounded. This is the most exhaustive study of the Marihuana problem to our knowledge, a sociological study dealing with the extent of marihuana smoking, methods of obtaining the drug, the determination of the districts in which it is sold, and the evaluation of the relations between marihuana smoking and crime. The second part of the survey consists of a clinical study to determine through experiments the psychological and physiological effects of marihuana on various types of people, to determine whether or not the drug causes physical or mental deterioration, and to discover possible therapeutic methods of treatment.

* * *

ARTERIAL HYPERTENSION, ITS DIAGNOSIS AND TREATMENT. By Irvine H. Page, M.D., and Arthur Curtis Corcoran, M.D., Research Division of the Cleveland Clinic Foundation, Cleveland, Formerly Lilly Laboratory for Clinical Research, Chicago, Illinois: The Year Book Publishers, Inc., 1945. Price \$3.75.

The diagnosis of hypertension, and the study of the eye grounds is given much attention, and minute description. The meaning and interpretation of the findings are important, but not exact. Other physical findings are given and evaluated. Complications, the circulation in early hypertension, the clinical considerations, the effects on the heart and coronary, the brain and the kidneys are all abundantly described. Treatment is given by thiocyanate, kidney extract, vitamin A, nephrectomy

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and sympathectomy. This book is intended for the guidance of the general practitioner who must treat these cases, and is of value to the specialist as well.

* * *

HOMICIDE INVESTIGATION. Practical Information for Coroners, Police Officers and Other Investigators. By LeMoyn Snyder, Medical Director, Michigan State Police, Member American Medical Association, Member American Bar Association. With Chapters by Captain Harold Mulbar, Chief of the Identification Bureau of the Michigan State Police, Charles M. Wilson, Director, Chicago Police Scientific Crime Detection Laboratory and C. W. Muehlberger, Director, Michigan Crime Detection Laboratory. Springfield, Illinois: Charles C. Thomas, 1944. Price \$5.00

Crime detection is probably the impelling interest in most detective story thrillers. Dr. Snyder has produced a book just as thrilling and attention-holding as most detective stories. He tells most interestingly the methods and resources used in searching solutions of crime riddles. The book is full of pictures, gruesome and repelling, but telling their story when the search is completely made. Details are of importance in this business of crime detection, and these methods may only be learned by studying methods that have been successful in the past, and drawing conclusions logically. For the officer charged with the duties of crime detection this book is indispensable, but it also has its interest for the doctor interested in "thrillers."

* * *

CASUALTY WORK FOR ADVANCED FIRST-AID STUDENTS By A. W. MacQuarrie, M.B., Ch.B. (Edin.) Admiralty Surgeon and Agent Civil Defense Medical Officer, Major and Battalion Medical Officer, Home Guard. Edinburgh: E. S. Livingston Ltd., 1944. Peter Reilly Co. Publishers, Philadelphia. Price \$1.80.

A small volume to go in the pocket, and containing accepted methods of first aid for burns, accidents, broken bones, treatment at the spot, methods of carrying, treatment of shock, hysteria, bleeding, pictures of the location of the big arteries that must be controlled, and how to do it. It contains instructions for attention to the unconscious patient. A valuable small reference.

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Views of the left hand of a male, aged 29 years; illustrating a *late atrophic arthritis*; duration of disease, 9 years; occupation, food storage, refrigeration.

This picture shows a terminal stage of rheumatoid arthritis. It illustrates, in addition to usual features of discoloration of the skin and wasting of the soft tissues, the presence of a cyst-like but actually a subcutaneous nodule on the second proximal interphalangeal joint of the index finger. Such nodules of a tubercle type occur, according to authorities, in about 10 per cent of patients with this disease. The fingers show atrophic changes involving particularly the third or middle digit. General involvement: including an ankylosing spondylitis or poker spine and locked jaws. This patient is also bedridden. X-ray shows marked subluxation in the metacarpal phalangeal articulations. There is irregularity of the articular aspects of the proximal interphalangeal joints and pronounced decrease of the distal interphalangeal joints. There is also loss of joint space of the carpal bones and resultant ankylosis. Note the generalized decalcification.



You and Your Business

MICHIGAN'S COMPULSORY HEALTH INSURANCE PROPOSAL

A compulsory health insurance bill was introduced into the Michigan Legislature on April 5. Allegedly sponsored by the CIO, the proposal is identical to a bill (A. 449) presented to the California Legislature last January by the CIO of that State. The California bill never came out of committee. The same fate met the Michigan edition.

The bill called for all employers and employees to contribute one and a half per cent each of an employee's salary to a state health insurance fund. This payroll tax would apply to salaries up to \$5,000 a year. The measure would create a seven-member health insurance commission with only one practitioner of medicine thereon! The others would be two members representing labor, two representing employers, one research man from a medical school, and one from the general public.

The state agency would have authority to co-operate with the government in any federal extension of health insurance.

Under the bill, no fee for service would be allowed; a practitioner would be paid by the state through straight salary or upon a capitation basis. No agriculturalist, or self-employed person would be a recipient of services under the bill until certain "studies" of their proposed inclusion under the plan had been completed. The medical cure and hospitalization of indigents are not mentioned in the bill.

The executive director at \$15,000 a year can not be a doctor of medicine; the medical director at \$12,000 a year must be one selected because he favors the philosophy of state medicine.

H.B. 423 was not considered seriously by the 1945 Michigan Legislature. That was realized by the proponents of the measure even before the bill was introduced. Their action seemed to be for publicity purposes.

The introduction of H.B. 423 is the indication of a trend. The people want medical security and because most of them (75.4 per cent) have never heard of voluntary programs sponsored by the medical profession, they look to government to do the job.

When given a choice between voluntary pre-

payment programs sponsored by the medical profession vs. a government-controlled program, more than twice as many people vote for the former, as shown by the Michigan Survey sponsored by the Michigan Health Council (1944). The people have faith in the medical profession and prefer to co-operate in a voluntary program operated by doctors. That program must be broadened and universally accepted in the next two years, to insure a continuance of quality medical care to the people and the preservation of the time-tried methods of private practice which have made American medicine the greatest in the world. Let's do everything to keep it that way.

GI BILL AND MEDICAL VETERANS

Michigan has over twenty-two hundred doctors of medicine in the armed forces and is justly proud of their records. From the South Seas to Alaska, in Europe and far away India, Burma and China, these men of medicine are doing a magnificent job.

As V-Day approaches, our doctors are thinking of home, families and their profession. Many of them have not had an opportunity to advance in civilian surgery or medicine. The civilian parade has passed them by. What will they do on their return?

Uncle Sam has provided the GI Bill of Rights (Service Adjustment Act of 1944) to assist doctors in their readjustment. Most doctors are over thirty years of age. Under the GI Bill, if they serve ninety days and receive a discharge other than dishonorable, they are entitled to a one-year refresher course in any professional school in the United States. The school must be approved by a State agency, designated by the Veterans' Administration. They are also entitled to \$50 per month subsistence allowance if single, and \$75 per month if they have one or more dependents. The Government will also pay up to \$500 a year for tuition, laboratory, library, health, infirmary and other similar fees, and for books, supplies, equipment and other necessary expenses.

(Continued on Page 434)



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GI BILL AND MEDICAL VETERANS

(Continued from Page 432)

The State of Michigan has an Office of Veterans' Affairs at 300 North Grand Avenue, Lansing, Michigan, which has been established for the convenience of the veteran. Communications as to a medical officer's rights as a veteran will be welcome.

MICHIGAN MEDICAL SERVICE SURGICAL BENEFITS INCREASED

1. \$150.00 Maximum.

This (Exception 5 in the old contract) has been altered to provide full surgical service for those conditions requiring multiple stage operations such as operative tuberculosis and cancer.

2. Maternity Benefits

The waiting period will apply to childbirth and is reduced from ten to nine months.

Miscarriage, ectopic pregnancy, et cetera, will be covered from inception of the contract.

3. Self-inflicted Injuries

This exclusion (Exception 4 in old contract) has been eliminated.

4. Out-Patient Service

Emergency service in the out-patient department of the hospital will be provided for accidental injuries. This will not include out-patient x-ray service.

And, in addition

5. Pathology

By a special rider contract, Michigan Medical Service will provide pathological laboratory services to all subscribers of Michigan Hospital Service.

**ALL THESE NEW BENEFITS BECAME EFFECTIVE ON
APRIL 1, 1945, FOR ALL SUBSCRIBERS**

MEDICAL CERTIFICATE NECESSARY FOR MARRIAGE

There is no provision in the prenuptial physical examination law of Michigan (Act No. 207 of the Public Acts of 1937, as amended) which authorizes Probate Judges to permit marriage without the proper medical certificate. When the applicant is free of venereal disease and the laboratory tests are negative, the medical certificate (Form C90) may be filled out by any licensed physician. When there is reason to suspect that

an applicant has venereal disease either from history, physical examination or laboratory findings, application must be made to the State Commissioner of Health for a special medical certificate. Such application should be made on Form V94. Persons with syphilis whose infection is in such a stage that it will constitute no danger to the health of the proposed marital partner or to any children which may result from the marriage, may be granted the special certificate.

Prior to 1945, the law made no allowance for pregnancy. However, the Venereal Disease Control Committee of the Michigan State Medical Society presented to the 1945 Michigan Legislature a bill to permit marriage in time to make the child legitimate provided the applicants demonstrate their co-operativeness by taking intensive antisiphilitic treatment over a period of time depending upon the expected date of delivery. This bill was enacted into law in April, 1945.

RESOLUTION ON MICHIGAN MEDICAL SERVICE

WHEREAS, in 1942 the Oakland County Medical Society opposed the operation of Michigan Medical Service, and

WHEREAS, Michigan Medical Service has now demonstrated its ability to progressively meet and correct its problems of management and operation, therefore

BE IT RESOLVED, that the Oakland County Medical Society go on record as encouraging the operation and extension of Michigan Medical Service and further resolve to continue co-operation with Michigan Medical Service in its efforts to render service to the public, and to meet the increasing demand for prepaid medical service.

Resolution approved at regular meeting of the Oakland County Medical Society, Wednesday, March 7, 1945.

DUES OF NEW MEMBERS

The dues and assessments of the Michigan State Medical Society for NEW members only are prorated according to the quarter of the year in which the NEW members are certified to the Michigan State Medical Society, as provided in the MSMS By-Laws, Chapter 1, Section 3.

The MSMS annual dues are \$12. The special assessments for 1945 (\$10.00 for public educa-

(Continued on Page 442)



When patients are subjected "to some physiologic strain, a febrile illness, hyperthyroidism, a period of unusual exertion, an attack of diarrhea, an operation, or perhaps mere curtailment of food intake, then nutritive failure is precipitated and evidences of ill health appear."¹

Vitamin reserves may be too meager to withstand increased metabolism or decreased ingestion. One way to spare patients the added debilitating effects of nutritive failure is to prescribe Upjohn vitamin preparations.

UPJOHN VITAMINS

1. Bull. N. Y. Acad. Med. 18:497 (Aug.) 1942.



DO MORE THAN BEFORE — KEEP ON BUYING WAR BONDS

It's The Law, Doctor!

Juris ignorantia est, cum jus nostrum ignoramus—Old Maxim.

NOTES ON COURT DECISIONS, STATUTES AND OTHER AUTHORITIES

Corporate Practice of Medicine—Public Policy—Debasement of Profession

J. JOSEPH HERBERT, General Counsel, MSMS
Manistique, Michigan

The growth of the movement toward group medicine has recently occasioned judicial re-examination of the question of the right of a corporation to practice medicine. So far, there appears to be no tendency on the part of the courts to retreat from their well-established position that corporations may not engage in the practice of medicine through licensed personnel. And the fact that the corporation does not itself undertake to perform medical service, but merely provides competent physicians chosen by it and not by the persons to be treated, who are directly compensated by it for actual services and not by salary, regardless of services, has not changed the rule.

Of late cases, *BARTRON v. CODINGTON COUNTY*, decided in 1942 by the Supreme Court of South Dakota (2 N. W. (2d) 337), because of its lucid and forthright expression and strongly reasoned argument against the corporate practice of medicine, is of unusual interest.

The facts of the case, as set forth by the Court, are as follows:

"The 'Bartron Clinic' was incorporated in February of 1929, 'to conduct and operate a general medical and surgical hospital and clinic and employ duly licensed physicians, surgeons, nurses, students, and other persons to carry on the business of said corporation.' Its 750 shares of capital stock were originally issued and held by duly licensed physicians and surgeons, and by nurses and other employes of the corporation. During the period of time at issue in these causes, only 28 of its shares were held by Joyce H. Williams, a lay person. The remaining shares were held by Dr. Bartron and Dr. Brown until 1936, and thereafter by Dr. Bartron. Joyce H. Williams was secretary of the corporation and served on its board of directors. It operated a hospital and clinic at Watertown until May 1, 1937. Thereafter, until June 15, 1938, it confined itself to a general medical and surgical practice, in connection with which it furnished its patients medicine. * * *

"Except for some minor services of an intern, all of the professional services involved herein were performed by duly licensed physicians and surgeons employed at fixed salaries by the corporation, and all charges therefor accrued to and were made by the corporation. The corporation owned all equipment used by the doctors and maintained the supply of drugs furnished patients. The corporation did not hold a license to practice medicine and surgery, nor to operate a pharmacy.

"On January 3, 1933, the county and corporation executed and delivered two contracts in writing wherein the corporation agreed to furnish hospitalization, medical and surgical services and medicine to the county for its poor persons. These contracts were renewed from year to year until 1937. * * *

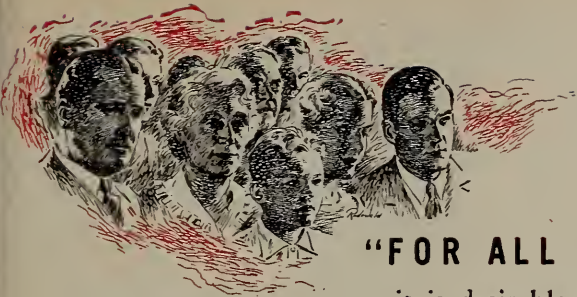
"The court further found that there was not in connection with the organization of the Bartron Clinic, or at any time thereafter, any purpose or intent whatsoever on the part of Dr. Bartron or anybody else connected with said corporation to place the actual control of the practice of medicine with any person other than duly licensed physicians; that there was not at any time throughout the existence of said corporation any control, or effort to exercise control, as to the actual practice of medicine on the part of anybody other than a licensed physician and no interference, or attempted interference, by anybody other than a licensed physician, with the actual practice of medicine; that the actual purpose and intent of Dr. Bartron in promoting the organization of said corporation was to establish what amounted to a system of profit sharing, whereby the prominent and leading employes of said hospital and clinic business would have some actual interest in the success thereof."

It is interesting to note that although it was strongly urged upon the court that the clinic contracts were in contravention of the medical practice act of South Dakota, the Court did not predicate its ultimate conclusion upon such alleged violation. On the contrary, it decided that the Bartron Clinic had done nothing in violation of the medical practice act, an act which is substantially similar to that in force in the state of Michigan. The Court's decision rests squarely on the naked proposition that the practice of medicine by a corporation "contravenes the public interest and is contrary to public policy."

After reviewing a number of cases from other jurisdictions, the Court said:

"Debasement of the learned professions is in fact inimical to the public welfare. The public is the ultimate beneficiary of its professional social organisms, and of the private, as well as of the unselfish public, exercise of the skills and talents of its professional practitioners. Although the members of the legal profession in their individual capacities as officers of the courts of justice

(Continued on Page 438)



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fore meals, thereby facilitating maximum absorption.

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INDICATED in the treatment and pre-

vention of anemias due to iron deficiency; especially valuable in patients who do not tolerate other forms of iron.

DOSAGE: Average dose for adults is 3 to 6 tablets (5 gr.) or 4 to 8 teaspoonfuls elixir daily; for children, 1 to 4 tablets (2½ gr.) or 1 to 4 teaspoonfuls elixir daily.

FURTHER FACTS FOR YOUR REFERENCE FILE AND CLINICAL SAMPLES WILL BE GLADLY SENT ON REQUEST

*Reznikoff, P. and Goebel, W. F.: J. Clin. Investigation 16:547, 1937.

TRADE MARK FERGON—REG. U.S. PAT. OFF.

NOTES ON COURT DECISIONS

(Continued from Page 436)

sustain a relationship to the public without parallel in the medical professions, in all other respects the services of the two professions are of equal importance to the public, and debasement of the one, in our opinion, would constitute no less a public evil than would the degradation of the other.

"These professions, as they exist in our social structure, rest upon a foundation of sturdy, sterling human character which, in turn, has been and is being shaped and moulded by the impact of traditional ideals and points of view. The licensing statutes with their emphasis on character and professional conduct evidence a fixed public desire and will not only to foster, but to develop and reinforce, these basic attributes of its professional servants. The constant trend of public demand, as exhibited by these licensing statutes, is for mounting standards, a more painstaking investigation of the character and professional conduct of applicant for entrance into these regulated fields, and a more constant vigilance in observing the conduct of those to whom the privilege of practice has been granted. Manifestly, that which has a tendency to blight the character or lower the standards of the business or professional practice of these individuals would be in contravention of the public aspirations so clearly reflected in the licensing statutes. Thus we conclude that debasement of the professions is not only inimical to public welfare in fact, but is in contravention of an established and fixed community want.

"We are therefore persuaded that that which tends to debase the learned professions is at war with the public interest and is therefore contrary to public policy.

"Does practice of the learned professions by a profit corporation functioning through duly licensed practitioners tend to debase the profession?

"We pause to emphasize the word 'tend' because the learned trial court has found that the Bartron Clinic was innocent of any unethical intention or practice, and that its licensed officers and employees controlled its professional activities. Our present concern is with the tendency of the challenged conduct. Though the exhibited instance of that conduct has accomplished no evil, if its inherent tendency be at war with public interest, it is contrary to public policy. *MOORE vs. HYDE*, supra.

"Because of the rights with which the law invests a stockholder in a corporation for profit, recognition of such a means of conducting a professional business involves yielding the right of participation in control of its policies and in its earnings to lay persons. A share in the fees of professional men would come to the owners of capital stock as a matter of right in the form of dividends. The stockholder's right to vote his stock would provide him with an instrumentality to be used for shaping policy. Ownership of stock would ordinarily qualify him to serve as a director or officer of the company. Lay ownership of stock would be ultimately assured by the incidental rights of transfer and suc-

cession. The object of such a company would be to produce an earning on its fixed capital. Its trade commodity would be the professional services of its employees. Constant pressure would be exerted by the investor to promote such a volume of sales of that commodity as would produce an ever-increasing return on his investment. To promote such sales it is to be presumed that the layman would apply the methods and practices in which he had been schooled in the market place. The end result seems inevitable to us, viz., undue emphasis on mere money making, and commercial exploitation of professional services. To universalize the use of this method of organizing the professions, or to permit such a use to become general, would ultimately wipe out or blight those characteristics which distinguish the business practices of the professions from those of the market place. Such an ethical, trustworthy and unselfish professionalism as the community needs and wants cannot survive in a purely commercial atmosphere.

* * * "That such is the tendency of the profit corporation when used to conduct a professional practice is not a matter of mere fancy or conjecture. It is a matter of common knowledge that this form of organization has been tried in the field of dentistry and resulted in such unethical and commercial practices as induced the Legislature of this and many other states to pass statutes expressly prohibiting its use.

"Being convinced that the practice of the learned professions by a profit corporation tends to the commercialization and debasement of those professions, we are of the opinion that such a mode of conducting the practice is in contravention of the public interest and is against public policy. It follows that we are of the view that in so far as the bargains of the Bartron Clinic and Codington County dealt with medical and surgical services, they were illegal."



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The Business Side of Medicine

A REPORT OF WARTIME LIQUIDATIONS

By Henry C. Black and Allison E. Skaggs

Battle Creek, Michigan

The Emergency

When the bombs fell on Pearl Harbor thousands of physicians from all over America were faced with the immediate problem of closing their offices, liquidating their accounts, paying up their bills and generally putting their financial house in order. These doctors, by common agreement, probably had more to lose financially than any other group called upon to serve their country in the emergency, and the amount outstanding on their accounts when they left played a very important part in their effort to leave a nest egg at home for the protection of their families.

The Opportunity

Our previous experience in the liquidation of the practices of doctors for whom we were working¹ and the more leisurely experience gained in the supervision of many doctors' offices (while the doctor was serving as Reserve Officer prior to December 7, 1941) made us the logical agent to step in and offer our services to those men who so willingly entered the service during the early months of the war. These men already knew us; the necessary confidence in our integrity and ability was already there; no selling problem existed; the service was immediately available without any discussion of fees. As a result, most of the doctors, for whom we were working at the time they left, availed themselves of our services, as did many others who had had no previous experience with us.

The Details

None of us fully realized in the beginning just how big a responsibility we were accepting, and the doctor, even less than we, realized how little attention to financial details he was going to pay just as soon as his military service began. In addition to collection routines, there were income tax figures to accumulate, final social security and withholding tax returns to file, life insurance premiums to pay (or arrange for deferment), many little things to be done and at a definite time and the records in our office made all this possible.

The Figures

During this three and a half years, Professional Management has furnished such a service to well over one hundred members of the Michigan State Medical Society, from north to south and from Lake Michigan to Lake Huron, in small villages and in the largest city. The total receivables of these men when they entered service, some of them in recent months, added up to slightly over \$1,000,000.00, on which has already been received by the doctors, \$500,000.00, and several hundred dollars per month is still coming in. In this

whole liquidation procedure, no funds were actually handled by our office, except in the few cases where personal bills were to be paid, et cetera.

The Cost

Our first desire was to assist our doctors in every way possible; profits were not expected, yet we felt the liquidation should be self-supporting. It was, and at the same time the average cost to each doctor for all this service averaged less than 10 per cent of the total collected, but the experience gained and the almost unanimous letters of compliment and appreciation received from our doctors has paid us in lieu of any profits that might have been realized.

The Reason

Writing in this JOURNAL several years ago², we mentioned the importance of good will and psychological approach in the collection of accounts. This was emphasized in our recent experience and from comparative studies made recently we are convinced that the average experience was far less successful than ours and for the following good reasons. Haphazard and poorly timed collection procedures never were satisfactory and are even less so in a time like this.

The Method

When the Doctor received his call to active duty, this organization closed his office, and brought his financial records, patients' accounts, et cetera, to one of our three offices, immediately preparing letters of notification to patients on his letterhead and mailing them from his office address, telling all patients who still owed money where the account could be paid. The letter carried the information that the Doctor had offered his services to his country, and for the patients' convenience arrangements had been made whereby they could pay their account in person or by mail at a convenient bank in the neighborhood of his old office. Successive statements and letters, all signed by a "Secretary to Dr. ——" were similarly mailed at monthly intervals until such time as the account seemed to require further action, after which time the local collection agency was used.

The banks, which almost unanimously co-operated in the program wherever called upon, mailed the doctor's bank statement and canceled checks to our office, together with the names and addresses and amounts of payments received each month. This enabled us to keep the doctor's books posted regularly as well as to accumulate all necessary tax information currently; to re-

(Continued on Page 442)



"When American people as a whole are educated to the fact that their...physician is the one best qualified to give authoritative information on matters pertaining to health...then only may they properly be fortified against the inroads of disease."

Edit.: Ill. Med. J. 82:407 (Dec.) 1942

To the above we subscribe wholeheartedly.

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MANUFACTURERS

WARTIME LIQUIDATIONS

(Continued from page 440)

port to the doctor each month just what had been received and spent, after which the bank statements were forwarded to him or his family as preferred.

The Results

The statistics on our collection experience should be of interest to every practitioner and in order to present as nearly an average picture of the result as possible, we have selected the figures of twenty-five doctors who—

- (1) had been in practice several years before entering service,
- (2) had a gross income of more than \$10,000.00 and less than \$15,000.00 in 1941,
- (3) were users of our service before leaving,
- (4) used a bank to accept payments on their accounts.

The total amount outstanding on the accounts of these twenty-five doctors totaled \$172,777.93, or an average of \$6,911.12 per doctor and in many cases included some obviously uncollectible accounts. This is equivalent to between four to five months' business done preceding their departure. The average collected the first six months amounted to 35 per cent of the total outstanding, during the first year 48 per cent and for the first two years 62 per cent. As payments are still coming in from some of these accounts, the total will run well over two-thirds, after deducting commissions paid to collection agencies. Beginning with collection of 10 per cent for the first month and dropping down consistently month after month to about 1 per cent or less after the first year, the curve shows a very consistent trend. It is interesting to note, however, that over two-thirds of the total collected came in during the first six months, which bears out the importance of the prompt sending of statements in any office.

Of course, costs for such a service could be much lower than would be possible in any other method with which we are familiar. Our highest cost, including all services, was 13 per cent of the total collected; the lowest less than 5 per cent, and the average 8.2 per cent. The good will was in our favor while the lack of the personal contact between doctor and patient³ tended to minimize this advantage. The approach⁴ was most important, and while it had the desired collection result, we are sure that the doctors' good will when they return to practice will be much better than with the use of any other method, or with no method at all.

Conclusions

Several conclusions may be drawn from this experience.

1. A doctor should not expect to carry a total equaling more than two to four months' business on his books in normal peacetime practice.
2. Continued supervision of these accounts, followed by well designed collection correspondence, will keep these amounts at a minimum.
3. The accounts receivable have an important relation

to the estate, and plans should be made as to how they should be liquidated. (Many of our doctors have such instructions attached to or a part of their wills.)

4. Proper collection correspondence is a goodwill builder at any time.

References

1. Black and Skaggs: Liquidating Your Accounts. J. Michigan M. Soc., October 4, 1937.
2. Black and Skaggs: Patients' Accounts. J. Michigan M. Soc., June, 1939.
3. Black and Skaggs: When to Send Statements. J. Michigan M. Soc., January, 1937.
4. Black and Skaggs: Delinquent Accounts. J. Michigan M. Soc., April, 1937.

2004 Central Tower

Battle Creek, Michigan

YOU AND YOUR BUSINESS

(Continued from Page 432)

tional purposes and \$5.00 for the MSMS Medical Veterans' Readjustment Program) as levied by the MSMS House of Delegates in September, 1944, are payable with the dues.

New members admitted on or after July 1, 1945, pay \$13.50; after October 1, 1945, the total dues and assessments are \$6.75. These prorations apply only to NEW members.

"PET PEEVES"

Despite the fact that 91.6 per cent of the people of Michigan feel that doctors of medicine as a group are doing a good job for the public, the people have complaints.

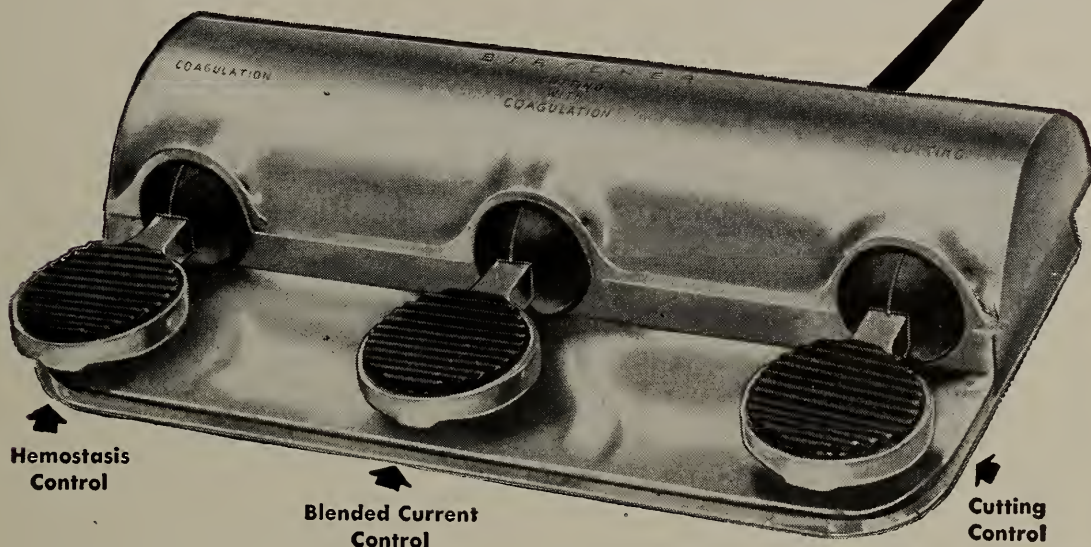
Their "pet peeves" regarding the medical profession are summed up in four classifications: Of the small percentage with peeves, 6.5 per cent felt that doctors overcharged; 4.4 per cent complained that physicians keep patients waiting; 1.7 per cent are of the opinion that doctors lack interest in their patients; and 5.6 per cent felt that some doctors are dishonest (from the Michigan Survey of Public Opinion, Sept., 1944).

The elimination of these complaints is the first responsibility of the medical profession. After that, the voluntary program plus the public relations work of the Michigan State Medical Society will be so effective that no individual or group—no matter how powerful they may think they are—can force the people to accept a compulsory system of government controlled-and-operated medicine.



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ST. MARY'S CENTENNIAL

St. Mary's Hospital, Detroit, dean of Middle West hospices, celebrated its One Hundredth Anniversary, May 16 and 17, marking a noteworthy milestone in the medical and social history of this teeming city.

The two-day celebration opened with a Thanksgiving Service followed by a medical clinic conducted by internationally famed physicians and surgeons.

The list of high ecclesiastics and notables participating in this historical program included Most Reverend Edward Mooney, D.D., Bishop Woznicki, the Most Reverend William F. Murphy, D.D., Governor Kelly, Mayor Jeffries, Msgr. Edward J. Hickey and Dr. Arturo Castiglione.

Dr. E. V. Joinville, president of the hospital's Executive Committee, related these highlights from the institution's long story:

"In June, 1845, Detroit was a bustling border town of some 11,000 souls, a town of small homes and large families, with 144 years of lively history behind it, and most of today's civic advantages in front of it . . . yet to be won. The story of St. Mary's actually begins a few years earlier, in 1833, when the Sisters of St. Claire from Bruges, Belgium, established a seminary for girls in two buildings on the corner of Larned and Randolph Streets.

"Though the location was considered somewhat remote at the time, the school flourished. The Sisters of Charity of St. Vincent de Paul assumed charge in 1844, and opened the school to both boys and girls, enrolling a representative group from throughout the city. Within a year's time the experience of the Sisters of Charity influenced them to transform one of the buildings into a refuge for the sick and indigent.

"Painfully aware of the distressing lack of any organized facilities for the care and treatment of the numerous sufferers from the contagious diseases and other ailments of the period, the Sisters determined to remedy the situation. They officially opened their hospital on June 9, 1845. It was Detroit's first, and was established as a charitable, nonsectarian institution of thirty-bed capacity, named St. Vincent's Hospital.

"The nursing was done by four Sisters under the supervision of Sister Loyola. She established and maintained the precedent, 'We must take care of them all.' None who applied for help was turned away. Lumberjacks, rivermen, representatives of all shades of the motley life of the town were cared for, regardless of ailment, creed, or nationality," Dr. Joinville said.

"Cholera struck the city in the summer of 1849, and with dread efficiency snuffed out, in two short months, one life in every twenty. More than a thousand died in July and August in that fateful year, despite the tireless efforts of the Sisters during the epidemic. However, their zealous care caught the attention and appreciation of the entire citizenry. In addition to their overcrowded hospital, they had succeeded in maintaining the school, with its more than 100 pupils. Antoine Beaubien generously donated a plot of his property on what is now St. Antoine Street, extending from Clinton to Mullet Streets. Public subscription raised \$10,000, and a new larger hospital was built. It was formally opened November 6, 1850, and was renamed St. Mary's Hospital. Thus the Sister's dream of a new and modern hospital—now 150-bed capacity—was realized.

"With the new facilities the sisters inaugurated a new service, then a startling innovation. It was an Out-

patient Department for those who were unable to pay for medical or surgical care, and who could be treated without hospitalization. It grew to major status throughout the years, blazed a pioneer trail.

"In 1859 the organization of the hospital was firmly established by incorporation under the laws of the State of Michigan, on February 5. The following decade, which of course covered the momentous war years and their troubled aftermath, saw no marked changes in the size of the institution, but was rife with progressive adaptations in its functions. By 1870 Detroit's population had risen to nearly 80,000 and Harper and Grace Hospitals had been founded. Dr. Theodore McGraw and Dr. William Brodie, prominent staff members at St. Mary's, were among the leading advocates of teaching medical students from actual hospitalized cases. Their goal was realized in 1869 when clinical sessions were held for the first time in the city's three hospitals. Since that time St. Mary's Out-Patient department has permitted the Wayne University College of Medicine to use all its cases for teaching purposes, a substantial contribution over the ensuing seventy-five years."

St. Mary's was also a pioneer in establishing a training school for nurses. The hospital's "School of Nursing" was organized in 1894 and since then has kept well abreast with the advances of the profession and the social field, according to Dr. Charles H. Clifford of St. Mary's staff. The hospital attic was remodeled into small apartments, with reading and recreation rooms, and the student nurses made their home there.

In 1916 a five-story Nurses Home was erected with the accommodations for ninety nurses at a cost of \$70,000. Between the first and second World Wars its occupants' energies were devoted to the Out-patient and Social Service Departments.

The school, which developed greatly under the supervision of Sister Bertilla, is a member of the State Registration Board. It is instructed by members of the staff, and specially trained graduate nurses. In the present emergency, it points with justifiable pride to its numerous graduates playing a vital part in their profession in the Armed Services. Among the graduates who are 2nd Lieutenants in the U. S. Medical Corps are these Detroit women: Florence Berger, last reported in Italy, Mary Fesenmyer, Rosemary Jarussi, Rita Kleffner, Angela Mason, Mary Jo Currotto, and Antonina DeJackobeck.

Of the present modern, Class "A," A.M.A. rated hospital plant, only the weather-beaten facade of the hospital's main entrance at 1420 St. Antoine Street remains unchanged from the year of its formal opening, 1879. This building contains a chapel, many times enlarged, in charge of Monsignor H. J. Kaufmann, hospital chaplain. It has a capacity of 250 persons, forms an integral part of the hospital.

In 1916 the institution was expanded greatly. The four-story Mullett Street and the three-story Clinton Street wings were added, the five-story Nurses Home built. In 1927 a large modern powerhouse was constructed at Hastings and Mullett Streets to safeguard St. Mary's against all functional emergencies. In con-

(Continued on Page 489)



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MSMS TELEPHONE CONFERENCE

Tuesday, April 3, 1945

Place.—From Neff Radio Studios to seventeen State Society Presidents.

Participants (Detroit end of hook-up): ANDREW S. BRUNK, M.D., and L. FERNALD FOSTER, M.D.

Time—11:05 P.M.—Eastern War Time.

DR. FOSTER—Good evening, gentlemen. This is Foster, Secretary of the Michigan State Medical Society. We have seventeen states linked together by wire for this telephone conference. To acquaint all with those present may I call the roll by states alphabetically. As I call your name please answer, giving name, state and office.

Connecticut, Delaware, Illinois, Indiana, Iowa, Kentucky, Massachusetts, Minnesota, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Washington, D. C., Wisconsin. Fine. All present.

Now it is my privilege and pleasure to turn the phone over to Dr. Andrew S. Brunk, President of the Michigan State Medical Society. Gentlemen, this is Dr. Brunk.

DR. BRUNK—I count it a great honor to meet and greet through the telephone this very distinguished group of leaders in the Medical Profession. It is also a genuine pleasure for me to extend to you, on behalf of the Michigan State Medical Society, an official invitation to come to Detroit on April 27 and 28 as our guests. We have some problems which we believe are of real importance to the Medical Profession, and would like your help and advice. We have arranged a program which we believe will be of interest to you. I shall be looking forward with pleasure to meeting you personally on the 27th. I will now ask our Secretary, Doctor Foster, to take the telephone and outline, for you, the program we have arranged.

DR. FOSTER—Thank you, Dr. Brunk. Gentlemen, here is the program we have arranged for your entertainment. Will each of you please accept this as an individual person-to-person call?

Doctor, upon your arrival in Detroit on Friday morning, April 27, please go direct to the Wardell-Sheraton Hotel. This is one of our best apartment hotels and room has been reserved for you there. I shall be there to greet you.

At noon you are to have luncheon with the Executive Committee of the Michigan State Medical Society at the Detroit Athletic Club. Transportation in private cars will be furnished.

At 2:00 p.m. we would like to take you on an inspection tour of the headquarters of the Michigan Medical Service, our voluntary group medical care plan. These headquarters are near the Athletic Club.

At 5:30 p.m. you are to join the Executive Committee of our Society for refreshments, to be followed by dinner at the Wayne County Medical Society's headquarters.

At 7:15 p.m. (and this is one of the highlights of the trip we believe), you will hear our Radio Program coming from station WJR. The Michigan State Medical Society is paying \$11,000.00 for this program and we believe you will enjoy it. A discussion of this radio hour and its development will follow.

Later, the stars of the Michigan State Medical Society's radio program will join us at the Wayne County Medical Society's headquarters and entertain you in person.

After nightcaps, to the Wardell Hotel for an overnight stay as we have something for you on Saturday morning. This something is a tour of the great Willow Run, the Ford Bomber Plant. Special deluxe buses will take you to Willow Run and return you to the hotel.

Our Executive Committee has its regular monthly Council meeting also on Saturday morning, so if you prefer to sit in on that meeting instead of making the trip to Willow Run, you're welcome to do so.

Well, Doctor, that's our program and we hope you can come. The Michigan State Medical Society is assuming the total expenses of your trip—transportation—hotel—cabs—even the tips. Our purpose in inviting you is to show you what we here in Michigan are doing and trying to do, and to get your reactions, advice and help.

I'll repeat this invitation. We want you to come to Detroit as our guest on Friday and Saturday, April 27 and 28, and sincerely hope you can be with us in your official capacity as an officer of another active State Medical Society. If you cannot personally accept this invitation (and we hope you can), we shall appreciate your wiring us collect at once, so stating and giving us the name of your proxy, such as your President-elect or Chairman of your Council or the Secretary of your State Society, who may be able to come in your stead. Wire our Chairman of Arrangements, Dr. Clarence L. Candler, Eaton Tower, Detroit 26, Michigan.

And now here's our President. It's all yours, Dr. Brunk.

DR. BRUNK—Gentlemen, may I again urge you all to accept this invitation. I'm sure you will find the trip interesting and beneficial and I know the Michigan State Medical Society will be greatly benefited by your presence. A letter containing full details of this invitation will go forward to you shortly. I'm indeed happy to have had this unusual opportunity, and look forward to greeting you all personally on Friday, April 27. Thanks again, gentlemen, and good night.

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A report on the successful Conference of Seventeen State Medical Society Presidents, held in Michigan, April 27-28, will appear in the next issue of JMSMS.
—EDITOR.

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Peripheral Vascular Disease

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Our understanding of vascular disease is daily enlarging. Its recent progress is explained by newer knowledge pertaining to the dynamics of circulation and by a closer study of the changes occurring in the clotting mechanism. For the general practitioner, the disturbances of peripheral circulation are most important. Acute vascular emergencies in the peripheral circulation include arterial thromboses, arterial emboli, and venous thromboses. The chronic vascular lesions are on an inflammatory, degenerative, or neurovascular basis. The purpose of treatment is obviously threefold: to relieve the obstruction, to develop and improve collateral circulation, and to remove non-viable parts at an optimal level.

■ THE creation of a specialty is justified only when it unites much scattered knowledge from different fields of medicine and applies it to the patient, thereby improving the results of treatment. This is certainly true in the case of vascular disease. Our present conception of this group of diseases has derived support from three distinct sources, namely, the study of the functional anatomy of blood vessels, the study of the clotting mechanism of the blood, and lastly from the study of the autonomic nervous system in its relation to

circulation. In the limited time at my disposal I can only point out the principles involved in the diagnosis and treatment of peripheral vascular disease, based on these three fundamental sources of information.

The Functional Anatomy of Blood Vessels

When an artery is obstructed because of an embolus, a thrombus or a ligature necessitated by hemorrhage, the viability of the limb supplied by that artery depends on the availability of collaterals. This collateral blood supply is notoriously abundant when the brachial artery is obstructed or when the femoral artery is tied just below the origin of the profunda. But an arterial obstruction in the axillary segment, or in the popliteal artery, carries a definite incidence of gangrene. There are three important factors to be considered. The first is of course the presence of good collateral blood supply, which is always better in the upper than in the lower extremities. For this reason, an embolus, a severe trauma, a frostbite is more dangerous on the lower extremity, although the status of the vasomotor apparatus, to be discussed later, will also modify this picture. But equally important is the fact emphasized by the Russian military surgeon Pokotilov¹⁷ and Emile Holman¹⁸ in this country, that a ligature or an occlusion, occurring just below a large collateral, will permit a far better blood flow and a higher blood pressure into the new available channels, than if the impact of pulse waves is lost into a dead-end type of vascular bed, which occurs for instance when the popliteal artery is occluded, and the long superficial femoral artery, below the profunda, has no vascular outlet of any size. When the patient who has had a slowly growing arteriosclerotic plaque in his popliteal artery suddenly develops an occlusive thrombus at this level,

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he is much more apt to develop gangrene or a severe ischemic paralysis than if his femoral artery became occluded at the groin. Lastly, the obliteration or destruction of the terminal vascular bed is always of grave importance, since if the arterioles are plugged no new circulation can be developed through them. Certain crushing injuries, frostbite and the terminal type of thromboangiitis obliterans are arteriolar injuries, and the chances of restoring circulation to such a part are much less favorable than if the major arterial pathways are obstructed.

The Clotting Mechanism

It is a curious fact that surgeons who deal daily with hemostasis have paid so little attention to the mechanism of blood clotting and especially to those patients who show an increased tendency to clotting. The first attempts were made in this direction by Bancroft and his associates¹ who developed a clotting index, unfortunately too involved to become generally useful. Quick's prothrombin time¹⁸ which shows so sensitively the increased bleeding tendency of the jaundiced patient or that of the newborn babe, can again only seldom detect a clotting tendency although, if determined on dilute plasma, very significant findings have been obtained.² Our group has found that patients who have just developed a thrombosis, those who have just gone through a major operation or suffered severe trauma to soft tissue, show a marked resistance to the action of heparin or dicoumarol and from this observation a simpler test of heparin tolerance has been developed.⁵ This test gives one an insight of what happens after a major operation, or why overdigitalized patients develop thrombosis,¹¹ or why sulfur compounds, such as sodium tetrathionate, improve the condition of patients suffering from Buerger's disease.⁶ We have also studied the effect of nervous factors on the clotting mechanism, which is a fascinating subject and explains why anger, fright or anxiety may add to the increased tendency to thrombosis.⁷

The practical application of such studies lies in the ability to pick out patients who are "clotters" so to speak, and who require steadily or intermittently the use of anticoagulants such as heparin, dicoumarol or some of the sulfur compounds which seem to improve the clotting mechanism. This factor in the production of thromboses needs emphasis since other factors such as

slowing of circulation or infection are fairly generally recognized.

The Vasomotor Apparatus

The vascular tree is not a set of rigid tubes, but a pulsating, elastic system, whose muscles can contract in response to direct trauma or to cold but which are also governed by the autonomic nervous system, which is predominantly vasoconstrictor. Stimuli, which affect the vasoconstrictors, include central, emotional stimuli, or reflex stimuli due to pain, heat or cold, food, and many other factors. But from a practical standpoint three outstanding stimuli dominate the vasoconstrictor apparatus, namely, cold, posture and nicotine.

Sympathetic vasoconstriction is completely abolished at 85° Fahrenheit, but any temperature below this will maintain a certain tonus. For this reason, in our climate, fluctuations of vasomotor tonus do affect the vascular tree and it is well known to all vascular clinics that the number of patients greatly increase with the advent of chilly weather. This does not mean, however, that 85° Fahrenheit is the optimal temperature for all patients suffering from peripheral vascular disease, since it may be too high for a patient with a severe vascular occlusion whose leg would be painless and safer at 70° Fahrenheit. A warm footbath followed by a woolen sock or a flannel boot over the affected extremity is the best protection against dissipation of heat without use of too much heat or too much cold. The idea of chilling or refrigerating an ischemic extremity is fraught with considerable danger, unless one has decided on an amputation. It is true that pain is effectively relieved, but if one expects to save an extremity refrigeration will only add the syndrome of an immersion limb of the shipwrecked sailors to the pre-existing vascular disease. It is a practice to be condemned unless it is used to eliminate pain and absorption from a *lost* extremity. Even then, I prefer to amputate under spinal or sodium pentothal anesthesia, since the healing of the stump is retarded by refrigeration.¹⁹

The effect of posture on vasomotor tonus has been much less often discussed. It is clear, however, that in man, the erect animal, vasoconstriction is marked during standing, especially in the lower extremities; only so can man maintain his blood pressure in the erect position. If one takes

blood pressures with a self-registering apparatus in the standing position one is amazed at the hypertension which prevails in the lower extremities of a normal individual. This may be the reason why arteriosclerosis, a result of tension in the blood vessels, is so much more prevalent in the lower than in the upper extremities of patients whose brachial blood pressure is normal. The diseased vascular tree can tolerate even less the increased vasoconstrictor tonus in the upright position. Putting the patient to bed effectively abolishes this postural tonus and if the temperature is equally under control is equivalent to a temporary sympathectomy.

The effect of nicotine on the sensitized or diseased peripheral vascular bed is so deleterious that nobody can effectively treat peripheral vascular disease unless smoking has been completely and permanently stopped. This is more easily said than done. It is true that the younger patient with thromboangiitis obliterans will respond more intensively to nicotine than the elderly arteriosclerotic. But it must be remembered that when circulation is impaired every small collateral is important and should be kept maximally dilated. For the arteriosclerotic group which has smoked for forty or fifty years, a cigar or cigarette may be allowed after meals, possibly accompanied by an alcoholic beverage. Both food and alcohol can neutralize the vasoconstrictive effect of nicotine, and so does sympathectomy.

Certain circulatory disturbances, such as the erythromelalgia of the aged, the burning pain in polycythemia and after partial nerve injuries are based on excessive vasodilatation. Vasodilator fibers may be present in the sympathetics but are mostly closely associated with the sensory nervous system. Such states are relieved by exactly the opposite type of measures which relieve vasoconstriction, namely, by cold, by elevation, by compression of the limb with pressures above systolic. Sympathetic paralysis may also favorably influence such conditions since the constrictor response of the terminal vessels to increased tension is abolished and the vascular throb is thus eliminated.

These are the three factors, then, which determine the prognosis and outline the proper treatment for peripheral vascular disease: the site of occlusion, the state of the clotting mechanism, and the vasomotor apparatus.

The Classification and Management of Peripheral Vascular Disease

The classification of the clinical syndromes is simple. The vascular lesion is acute or chronic, organic or functional.

1. *Acute Vascular Occlusions*

These are emboli from the heart or aorta or thromboses which form at the site of the diseased vessel.⁴ The acute lesions are always more dangerous since the collateral bed may be meager or may go into spasm at the time of the occlusion; also because of the increased tendency to clotting, or because of the disturbed cardiac mechanism, more emboli may follow to different parts of the body.

The emergency treatment of acute vascular occlusions consists of papaverine grains $\frac{1}{2}$ intravenously to release the reflex vasospasm, heparin 50 milligrams intravenously to prevent further clotting by apposition and a sympathetic block if equipment and trained personnel are available. Heparin and papaverine can be given every three hours, but if the color and temperature of the limb do not definitely improve, an embolectomy should be performed within the first six to ten hours after the acute onset.

The extraction of the clot and the suture of the vessel is not as hard as to know what to do with a long clot that often forms distal to the embolus and which prevents a reopening of the entire channel. If the distal clot is extensive, the best embolectomy is futile. Attempts to flush out or suck out the distal clot from a second opening may be successful.

The differentiation of a thrombus from an embolus is obviously important. When an extremity has suddenly become paralyzed, pale, numb, and pulseless in the presence of a pre-existing heart disease such as mitral stenosis with auricular fibrillation, bacterial endocarditis or a coronary occlusion with a mural thrombus in the left side of the heart, the diagnosis offers no difficulties. Embolic phenomena to brain, lungs, kidney, spleen or mesenteric vessels may have preceded the vascular occlusion. Nor is the diagnosis difficult when a complete closure of a vessel occurs in a patient who is known to suffer from a peripheral vascular disease such as Buerger's disease or arteriosclerosis obliterans. In such a patient a complete occlusion of a vessel develops at a site of previous inflammation or arteriosclerosis. Embolectomy is

here of no avail, but the resection of the thrombosed segment together with a paravertebral block is often limb-saving.

The real difficulty lies in the differentiation of an embolus which may occur in several showers with no obvious cardiac involvement from a thrombus which is the first clinical symptom of a latent vascular disease. The use of papaverine and heparin together with a paravertebral block is always useful. An electrocardiogram may reveal a recent unsuspected coronary occlusion. A blood culture may reveal a subacute bacterial endocarditis. A study of other parts of the vascular system may find evidence of occlusive vascular disease. Finally, as in cases of blunt injury, a segmental arterial spasm can be suspected which may subside spontaneously or end up in a segmental thrombosis if the artery itself is injured. Such segments need early resection to prevent propagation of the thrombus.

I have dealt in more detail with the acute arterial occlusions because they demand immediate, intensive therapy. Many limbs have been lost because the above-described early measures have been neglected. If on the other hand one sees an extremity several days after an acute vascular occlusion, the proper level and proper time of amputation should be carefully considered. These considerations will be discussed later.

2. Chronic Vascular Occlusions

A. The organic lesions of practical importance fall into an inflammatory and degenerative group. The specific inflammatory lesions, with the exception of syphilis, are rare; but an inflammatory lesion of unknown etiology is Buerger's disease, which is so frequently missed in its early stages.

Thromboangiitis obliterans.—Buerger's disease in the early stages may appear as a migrating phlebitis, a sudden occlusion of a digital vessel or a chronic recurrent arteriolar disease, with a rapidly spreading character. It affects young males, mostly smokers, who have their arches padded, their legs massaged, their toenails trimmed or removed until finally someone makes a diagnosis of an impairment of circulation. Yet in the early cases the abstinence from tobacco, a liberal fluid and salt intake, and a course of injections of triple typhoid vaccine or sodium tetrathionate can effectively stop the whole process. It seems as if in this early stage the vascular tree were sensi-

tized to a bacterial or toxic allergen and a non-specific desensitization can be readily accomplished. All sources of infection including ringworm infection should be systematically eliminated. Following the lead of Thompson²¹ and Naide¹⁶ we have tested many patients suffering from Buerger's disease with trichophytin and monilia vaccines and the skin tests were often positive. It is not to be supposed, however, that this is the only origin of sensitization, since nicotine and many bacteria may produce vascular allergies.

Most of the time, however, the surgeon sees the patient in a stage of segmental obliteration with reflex vasospasm and it becomes necessary to evaluate the extent of the organic damage against the functional element of vasospasm. This is readily done by measuring the skin temperatures of all five digits, the heel and dorsum of the foot before and after sympathetic block. One can also watch for a change in claudication time and the length of venous filling time before and after block of the regional sympathetics.⁸ It is important to note whether or not a certain toe remains cold or drops its temperature after block. Such a part will not improve after sympathectomy; on the contrary it may become gangrenous. For this reason one should consider removing such a toe or toes at the time of the sympathectomy if a rapid economic rehabilitation of the patient is to be accomplished. If the patient is doing manual labor or is exposed to cold winter climate, every effort should be made to reallocate him with the help of agencies to a job which does not expose them to additional injuries. When amputation is necessary it should be done at a level determined by histamine flares. Sympathectomy may permit a minor instead of a major amputation and effectively extends the level of adequate circulation to more distal segments.

Arteriosclerosis.—In the case of arteriosclerosis an early recognition is equally important. All of us have been trained to assume a fatalistic attitude toward the progress of arteriosclerosis. Yet in the presenile period of patients between forty and fifty or even earlier one can recognize the partial occlusions, mostly popliteal atheromas. The decrease of the blood cholesterol level by thyroid and low-fat diet, the feeding of choline or lipocaine have been advocated and seem to offer promise. Certainly weight reduction and a watchful control of a mild or latent diabetic metabolism

may do much to prevent the progress of the disease. The surgical control of juvenile hypertension by splanchnic nerve section will also control a progressive arterial and arteriolar sclerosis in the periphery. Lumbar sympathectomy offers great help for patients with early or moderately severe peripheral arteriosclerosis, since it eliminates the remarkable vasoconstriction which prevails in the erect posture. While there is much evidence in favor of a disturbed lipid metabolism being associated with fatty subintimal infiltration,¹² the so-called atheroma, the role of intravascular tension in the production of arteriosclerosis cannot be ignored.¹⁵ It must be remembered that every man is hypertensive in his lower extremities, and that by depriving his extremities from their vasoconstrictor supply, a lowering of peripheral resistance will result. If an arteriosclerotic extremity warms up well after sympathetic block, if his walking ability improves and his venous filling time decreases, one sees remarkable improvement in this group of patients provided sympathectomy is not done too late. This is equally true of the diabetic arteriosclerotic, except that his metabolism must be rigidly controlled.

There is no known vasodilator that would effectively influence the peripheral vascular tree, except for a very short time after its administration. This is true of histamine, of mecholyl, of the nitrite group and of "depropanex," a tissue extract which is painful to administer and throws an unwarranted financial burden on the patient. Our group has customarily prescribed theocalcin, or theobromine acetate, since a steady administration seems beneficial to the coronary circulation which is often involved in peripheral arteriosclerosis. Whether it does much good in the periphery is questionable. Theobromine or aminophyllin, given intravenously, demonstrably improves the pulse-waves in the periphery, but this action is of short duration. Papaverine, as described above, is only used in the acute vascular accidents in one-half grain doses. The prolonged use of papaverine by mouth in one-grain doses three times a day does not seem to accomplish much in the periphery and may confuse the patient and add to his addiction to narcotics.

For this reason, too, codeine is used very sparingly, in $\frac{1}{4}$ -grain doses, mostly in combination with 15-grain doses of aspirin. If this does not suffice for pain relief, barbiturates or bromides

may help; if the pain is intractable other forms of therapy must be considered.

Mechanical means of increasing the vascular bed are many; the Buerger-Allen exercises alternately fill and empty the venocapillary bed; however, they are not apt to be carried out for a long enough period each day and some patients are not strong enough to do it consistently. The suction pressure apparatus has given a great impetus to all mechanical forms of vascular exercise, but it is an expensive form of treatment which we have substituted with intermittent venous hyperemia.¹⁰ This form of treatment can be carried out at home with an ordinary blood-pressure apparatus, with a specially built leather cuff pumped by hand or with an automatic device operated by electricity, which the patient applies from two to twelve hours daily depending on the severity of his circulatory deficiency. The pressures and the time of constriction and release must be determined individually for each patient and so selected that during constriction a marked filling of the veins and rubor of the toes occur, whereas during release the limb takes on its normal color and the veins collapse. Many hundreds of our patients have used such an apparatus for months and years and have increased their walking ability to a great extent. Obviously the method has its limitations; it will seldom relieve rest pain, it will not eliminate but may increase vasospasm, nor will it restore circulation in a pregangrenous limb. Its greatest field of usefulness lies in diabetic and nondiabetic arteriosclerotics whose terminal vascular bed is fairly well preserved. The constrictor should not be used in the presence of phlebitis, lymphangitis, any spreading infection or moist gangrene. When a leg is amputated, the other leg, which is almost always involved except in the embolic type of gangrene, should be intensively treated.

Another device which has given our patients decided benefit is the oscillating bed. This supplies the patient with a Buerger-Allen exercise, without any effort on his part and for six to eight hours a day continuously. Patients who arrive at the hospital with intractable rest pain, only relieved by a dependent position and the consecutive edema, often sleep well on this bed after one or two nights without narcotics. After one month of treatment on such a bed the patient may continue at home with a rhythmic constrictor (intermittent venous hyperemia). However, often this

has just protracted the inevitable amputation which patients require with prolonged intractable rest pain due to ischemia.

B. The Functional Types of Peripheral Vascular Disease

Raynaud's disease, the symmetrical vasospasm of one or more digits, produces a triphasic color change in the affected fingers or toes. The digits turn waxy-white, then blue and finally red, which signifies the end of the attack. True Raynaud's disease is very rare, but the phenomena just described may appear as manifestations of almost any vascular disease. They must be excluded before a diagnosis of a primary vasospasm, followed by venous stasis and terminated by a reactive hyperemia, is made. If the attacks are frequent and last long enough, changes will occur in the vessel wall and in the soft tissues, which finally will lead to thrombosis of the vessels and sclerosis of the finger tips with ulcerations or patches of gangrene.

While many of the mild attacks in younger women can be left alone or treated with iron, arsenic and high vitamin intake, there is no real therapy known for the true progressive Raynaud's disease but sympathectomy. This must be done, as Smithwick²⁰ has shown us, in such a manner that regeneration is prohibited and that only preganglionic fibers are cut. Even so, in patients whose digits do not entirely warm up during the pre-operative sympathetic block, indicating vascular damage, color changes may persist after sympathectomy. The fingers may turn white and blue at their tips, but this is fleeting and the painful burning vasodilatation of the third phase is absent. Patients are so satisfied with the result that they almost invariably ask for the operation on the second extremity. Conditions which are of vasospastic nature, but do not show the triphasic reaction, include acrocyanosis, livedo reticularis, and supramalleolar erythrocyanosis. Also a certain number of poliomyelitic extremities show vasospasm since the virus may affect the lateral horn of the anterior roots thus irritating the sympathetic outflow. All such patients are greatly benefited by sympathetic ganglionectomy.

Attention should be called to certain vasodilator phenomena, which I have already mentioned in the discussion on the role of the vasomotor apparatus. They are usually associated with a partial nerve lesion, whether this be traumatic,

ischemic, or based on avitaminosis. Demyelination of roots and trunks, due to poor circulation and arteriosclerosis of the cord, is not infrequent in senility and produces the hot, burning hands and feet of patients who paradoxically may be pulseless. The causalgic states, which are so important in industrial accidents and in war injuries, are similar in that this throbbing, burning pain is relieved by elevation, cold, and sympathetic block. Why sympathetic block should be of any help here is rather remarkable. But there can be no doubt that it temporarily abolishes the burning pain or may relieve it for a long period of time. It may well neutralize or inhibit the pain-producing vasodilator substances, which form when posterior root fibers are stimulated.²⁰

Surgical Methods of Treatment

Sympathetic Block.—Procaine infiltration of the regional sympathetic chain is done as a test before any proposed sympathectomy, to overcome vasospasm in the acute arterial occlusions and repeatedly for the treatment of early causalgic states. The method can be acquired by some practice and requires 5- to 6-inch needles with 22 gauge to do it painlessly.

Sympathectomy.—The removal of the regional sympathetic chain has been performed in our clinic for selected cases of Raynaud's disease, Buerger's disease, arteriosclerosis obliterans, poliomyelitis with vasospasm, prior to operations on aneurysms requiring arterial ligation, for acute arterial thromboses of undetermined origin, and for late cases of frostbite.³ Fundamentally, all patients are benefited who show a good rise of skin temperature and other signs of increased vascularity after a sympathetic block. It must be stated with emphasis that blood flow *per se* is not permanently increased but that the lack of vasomotor innervation frees the blood vessels from a continuous play upon them mostly by cold and posture. The limbs are in such a state as if they were under a heat cradle with a temperature of 85° Fahrenheit and as if they were in a horizontal position. One can readily see that it quickly and permanently produces the benefits of lying in the warm sand in Florida or being at an absolute bed rest under a heat cradle.

Embolectomy.—This should be done six to ten hours after an embolic occlusion of a major ar-

terial pathway, if measures to induce vasodilatation by papaverine and sympathetic block have failed. Heparin should also be administered to inhibit progressive thrombosis below the occlusion. Acute thromboses will fail to respond favorably.

Arteriectomy.—This operation is indicated in cases of acute or chronic thromboses of limited extent, especially if they are due to trauma or to emboli seen late. When this is done, a simultaneous ligation of the concomitant vein is of additional benefit. Cervical ribs producing thrombosis or partially clotted aneurysmal sacs require arteriectomy preceded by a dorsal sympathectomy.

Amputations.—Minor amputations of toes or fingers should only be done if there is evidence of fair circulation at the level of amputation. Much damage is done by removing an arteriosclerotic, gangrenous toe, when the proper level of amputation is at the knee. On the other hand, a gangrenous toe of a patient suffering from Buerger's disease can often be safely amputated if the level of amputation is protected by a sympathectomy. The cutaneous histamine flares are very helpful in determining the lowest possible level of amputation.

If the amputated part is infected, the sutures may be placed loosely but the wound should be left wide open and packed with sulfanilamide gauze. Three to four days later, the gauze can be gently removed and sutures tied, leaving space between them for additional drainage.¹⁴ This principle permits of a more rapid closure than if a secondary closure or a second amputation has to be done. In critically ill, septic patients, a low guillotine amputation may be followed 10 to 14 days later by a second amputation at the site of election and loose closure.

The major amputation, 6 to 7 inches below the knee, through the condyles or supracondylar ones, is done with the same principle, namely, allowance for profuse lymph and plasma drainage followed by complete closure four to five days later. In aseptic cases primary closure is done but with the following precautions: no sutures to fascia or muscle, a spray of sulfanilamide powder to the wound, a simple ligature of No. 60 cotton to the nerve stumps without pulling them down or injecting alcohol into them, loose clo-

sure of skin without the slightest tension, no rubber or any other kind of drainage except that which occurs through the suture line.

Summary

A brief survey of the present status of the management of peripheral vascular disease is made. There is no conflict between conservative and surgical management, between sympathectomy versus amputation or between physical therapy against drug therapy. All these measures have their definite indications and limitations and are used in conjunction with each other for the best interests of the patient.

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MAXILLO-FACIAL INJURIES

A survey of the North African and Sicilian campaigns showed that of the total admissions to hospitals 0.5 per cent were for maxillo-facial injuries. Of these, forty-two per cent were battle casualties.

The incidence of maxillo-facial injuries compared to total battle casualties was about 2.2 per cent. In the cases reported, there were no deaths caused primarily by battle-incurred maxillo-facial injury.

A Rehabilitation Program for Military Veterans

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The world is facing its greatest problem in physical rehabilitation. A satisfactory over-all program must be developed.

The physical reconstruction of those disabled in war begins at the moment of injury and ends only when they are restored physically and adjusted mentally. Rehabilitation is accomplished in nine steps: (1) immediate emergency care; (2) secondary emergency care; (3) rapid transportation; (4) treatment in general hospitals; (5) treatment in rehabilitation centers; (6) vocational guidance; (7) vocational training; (8) selective placement; (9) industrial rehabilitation.

Following all previous wars, physical rehabilitation has been performed rather poorly. Physicians must begin at once to consider the contributions which they can make toward the solution of this vast problem. This time we must not fail.

■ THE establishment of a suitable rehabilitation program for military veterans presents tremendous problems. This is a fact which I have stressed repeatedly in recent publications.¹²⁻¹⁴ The magnitude of the problem is brought home by the recent statement of Gen. Frank T. Hines⁷, Administrator of Veterans Affairs, that through December, 1943, from all services 1,029,329 men and women were discharged to civilian life. Of this total, 428,728 were given a certificate of disability discharge. One can be certain, therefore, that by this time more than half a million persons have been discharged from military service in this war because of some physical or mental disability which must be corrected in the hope of obtaining complete readjustment in civilian life. General Hines pointed out that 34.5 per cent of these persons had some type of neuropsychiatric disability.

It is small wonder that Numainville and Kohn¹⁶, two Army physicians, writing recently on rehabilitation problems, stressed the point that

¹²Read before the Fourth Annual Postgraduate Conference on War Medicine, the Seventy-Ninth Annual Session of the Michigan State Medical Society, Grand Rapids, Michigan, September 28, 1944.

treatment must include not only the physical but the psychologic viewpoint as well. These officers stressed the importance of "rehabilitation consciousness" in training of "medical soldiers." I should go still further and stress the need for rehabilitation consciousness not only among "medical soldiers" but also among civilian medical workers and the public at large. In fact, it is not enough for the public simply to be aware of reconditioning and rehabilitation; they should have definite ideas concerning the scope of physical rehabilitation of the wounded and how they can contribute to the rehabilitation program. As Lord Horder⁸ put it, "reconditioning and rehabilitation are in the air; with many folk who pay lip service to these ideas they remain in the air." All of us, particularly we medical men, must get down to earth and decide how best we can contribute as individuals toward the rehabilitation of the ever-increasing number of our wounded military veterans.

Maj. Gen. Norman T. Kirk, the Surgeon General of the Army, has pointed out that "much of the finest surgery and rehabilitation work can be undone or will remain incomplete if the public at large fails to behave with restraint, intelligence and consideration." It behooves us as physicians to study the problems of rehabilitation and to familiarize ourselves with what is needed in order that we may pass on to the public at large the pattern for a sound, over-all program in physical and mental rehabilitation of disabled soldiers and sailors. In any program for rehabilitation of the disabled, physical medicine looms large. It is admitted that adequate employment of physical measures in rehabilitation is not the entire answer to our problem but it must be stressed that we physicians should be familiar with the part which physical medicine must play in an adequate rehabilitation program. The definition of physical medicine recently adopted by the Council on Physical Medicine of the American Medical Association¹⁵ is as follows: "Physical medicine includes the employment of the physical and other effective properties of light, heat, cold, water, electricity, massage, manipulation, exercise and mechanical devices for physical and occupational therapy in the diagnosis and treatment of disease."

You physicians of Michigan have demonstrated your keen perception of the magnitude of the over-all problem by the fact that you have or-

ganized this fine postgraduate conference on war medicine and further you have shown your realization of the importance of physical medicine by a recent action of the Council of the Michigan State Medical Society. I quote from the minutes of the meeting of the Executive Committee of the Council for February 24, 1944.¹ "Doctor Foster presented the recommendation of the Bay County Medical Society that the Executive Committee of the Council urge the Michigan medical schools to offer more training in physical medicine as well as the recommendation to the Michigan State Medical Society Committee on Postgraduate Education that it include lectures on physical medicine in the Michigan State Medical Society Postgraduate Extramural Courses." Favorable action was taken on this recommendation and it was moved that the Executive Committee communicate with the deans of the two medical schools in Michigan, urging them to stress the importance of physical medicine in their curriculums and also to suggest to the State Board of Registration in Medicine that they likewise write to the deans of the medical schools on this subject and further that the Committee on Postgraduate Medical Education be requested to include physical medicine in its courses for physicians of Michigan. This motion was carried unanimously.

Since the physicians of Michigan have shown such great interest in wartime physical rehabilitation, I shall try to sketch for you the steps in a suitable rehabilitation program. The Baruch Committee on Physical Medicine¹⁸ has defined medical rehabilitation as "the restoration of people handicapped by disease, injury or malformation as nearly as possible to a normal physical and mental state. Medical rehabilitation fills the gap between the customary end point of medical attention and the real necessity of many patients." The physical rehabilitation of a disabled soldier or sailor begins the moment he is wounded or becomes ill and ends *only* when he is finally restored to active duty or is completely adjusted physically and mentally in a suitable position in civilian life. To accomplish this lengthy transition, I have stressed repeatedly in recent publications that many of the disabled veterans must be taken through nine major steps, in all of which the medical profession must participate.

Step 1.—Immediate Emergency Care

This will usually be provided by the battalion or ship surgeon assisted by hospital corpsmen in the field. Advances in surgery and in chemotherapy are saving lives at this stage but also increasing the number of men who return with serious disablement for final rehabilitation.

Step 2.—Secondary Emergency Care in Advanced Hospitals Near the Field of Military Operation

Here the next step in rehabilitation will be performed by general surgeons, orthopedists, internists and other medical specialists assisted by members of the Nurse Corps, Physical Therapy Corps and hospital corpsmen. I agree with Numaiville and Kohn that "only profound realization of the importance of the early initiation of rehabilitation will enable the medical officer to do his full share in the forward echelons of the medical service, including the medical installation of the division area." During the last war it was soon found that early physical therapy was so important that physical therapy technicians were moved right up to the advanced general hospitals and now it is definitely specified in the Tables of Organization that all numbered general overseas hospital units shall have such technicians as part of the staff. They have proved extremely valuable in the early rehabilitation of the wounded. Often the injured man can be rehabilitated completely at this point and returned to active duty. If complete rehabilitation is not possible at this time, he probably will be returned to the United States for further treatment.

Step 3.—Transportation by Hospital Ship, Air Transport or Other Means

Rapid transportation of those disabled by war to larger medical centers in this country has assisted greatly in the more speedy rehabilitation of our wounded. This work has been accomplished by specially trained hospital ship companies and transport physicians aided by skilled nurses and corpsmen. Literally thousands of patients have been transported rapidly by air in this war, thus completely altering the picture of the medical rehabilitation of our wounded. The advanced echelons have been relieved of the care and rehabilitation of patients requiring prolonged treatment

and our boys have been transported at the earliest possible moment to the large general hospitals where every facility for rapid rehabilitation can be provided.

Step 4.—General Army and Navy Hospitals Within the Continental Limits of the United States

In the large named Army general hospitals and Naval hospitals in this country, the major part of the early rehabilitation of the seriously disabled is taking place. Here outstanding general surgeons, orthopedists, internists, physical therapy physicians and other medical specialists, assisted by nurses, physical therapy technicians, occupational therapy technicians and physical training instructors, work efficiently together in the rehabilitation of disabled veterans. Unfortunately, many physicians have not thought beyond this point and they believe that when a patient is dismissed from such a hospital, the physician's responsibility for him ceases. This was one of the great mistakes of our profession during the last war and, so far during this war, we have not devoted sufficient attention to the responsibilities of the medical profession in the final steps toward complete rehabilitation of military veterans. This failure to carry through with the final steps of an adequate rehabilitation program led to so many failures that Johnstone commented recently that "rehabilitation of our armed forces has been attempted following all previous wars *but has never been successful.*" If we are to succeed with our rehabilitation program for the first time in this war, I believe that we must carry our medical supervision a few steps farther.

Step 5.—Rehabilitation Centers in Army, Navy, Veterans Administration, State and Civilian Institutions

Already certain far-sighted American Army physicians have realized that their disabled patients cannot be rehabilitated readily by means of the usual hospital ward routine. Col. Clyde M. Beck, Commanding Officer at the Ashford General Hospital, has recently written to me as follows: "From my experience in the last war and as a medical officer since that time, I feel that one of the greatest steps which has been taken in this war has been the effort directed toward the rehabilitation of the injured soldiers. I firmly

believe that the health resort centers which are being used by the Army are playing an ever increasing part in this program." The British have realized the need for breaking away from the standard hospital routine and establishing special rehabilitation centers. The British Tomlinson plan¹⁷ has advocated special rehabilitation facilities for various types of disablement. The phase of physical rehabilitation which seems to have been most neglected in the United States is that which has to do with the development of these special rehabilitation centers in our governmental and civilian facilities. Many of these centers should be specialized for various types of cases and they should be provided with recreational facilities, physical therapy departments, occupational therapy departments, sheltered workshops and vocational training schools. We physicians must accept the importance of this part of the program for the rehabilitation of our war veterans because even our lay advisers recognize this fact. In their report on war and postwar adjustment policies, Bernard Baruch and John Hancock recommended that a work director be appointed in the Office of War Mobilization and that "he should develop effective programs in such fields as adequate care for returning veterans, physical and occupational therapy for wounded and disabled; the resumption of education for those whose schooling has been broken by the war; vocational training for all workers." This recommendation by Baruch and Hancock leads logically to the next step in our program.

Step 6.—Vocational Guidance

A well-organized vocational guidance program must be integrated with the medical rehabilitation of our disabled veterans. There is great need for the development of a group of fully qualified vocational counselors. The War Manpower Commission appointed a special advisory committee on vocational counseling and its chairman, Dr. Ernest J. Jaqua, commented in the Commission's Bulletin on Training of Vocational Counselors that "running through all the deliberations and recommendations of the Advisory Committee was the hope that something might be done to elevate the profession of counseling, to lift it from the plane of random advising which anyone can do who happens to be 'fond of people' into the realm of an exacting professional task requiring expert training and mature judgment." If

our over-all program for rehabilitation of wounded veterans is to succeed, we must have not only the well-trained vocational counselors but we must have direct medical supervision of the counseling program by trained medical psychiatrists. If this phase of the program can be developed satisfactorily, we may be able to overcome the mistake made in the last war in which the choice of vocational training was often so poor that it failed to rehabilitate the disabled veterans. Sometimes the training was useless, often it was beyond the intellectual capabilities of the person and frequently it was in a field in which there was no need for additional workers. The Administrator of Veterans Affairs, Gen. Frank T. Hines,⁶ has explained that after the last war, "Veterans were advised to undertake a training program for an objective which could not be attained." In this war, good vocational counseling under adequate medical supervision will obviate such mistakes.

Step 7.—Vocational Training Centers

The establishment of special vocational training centers in which normal industrial conditions will be approached closely and which will be operated by the industries as final training centers after graduation from training schools should assist in the transition of the disabled veteran from the status of a patient to that of a civilian worker. Here in Michigan with your vast industrial organizations, you are in an ideal position to inaugurate such programs. These industrial training centers should be operated by industrial instructors and selected factory foremen assisted by social workers, vocational counselors and placement workers, all serving under the direct medical supervision of qualified industrial physicians.

Step 8.—Selective Placement Boards

It should be the duty of the selective placement board, consisting of industrial physicians, psychiatrists, vocational counselors and industrial employment experts, to place each rehabilitated veteran in a suitable industrial activity commensurate with his limited physical capabilities. Your own Michigan physician and leader in the field of industrial medicine, Dr. Clarence Selby, at a recent meeting of the Joint Committee on Rehabilitation of the Councils on Physical Medicine and Industrial Health of the American Medical Association, pointed out that industry cannot well do any physical rehabilitation except "on the job."

He expressed the opinion that selective placement is the key to successful industrial rehabilitation and he thought that industry would need the guidance of psychiatrists in developing such a project. This Joint Committee on Rehabilitation sent a resolution to the Board of Trustees of the American Medical Association stating that "Private and industrial medical practice will become increasingly concerned with problems of reconstructive medicine and surgery and the rehabilitation of casualties of war and of war production. This committee is of the opinion (1) that the American Medical Association should emphasize strongly that rehabilitation is primarily a medical function, (2) that the medical profession be widely informed of legislative proposals in this field and (3) that efforts be made to insure proper participation by the medical profession in all rehabilitation plans now being formulated."

Step 9.—Industrial Rehabilitation

Finally, in order to complete the adjustment of the disabled veteran to his life's work, it is essential that industrial medicine, which is so strongly represented here in Michigan, should rise to new heights in the care of this special class of workers. Fisk has pointed out that "the final test of rehabilitation is permanent employment at a job consistent with the ability and preparation of the veteran at a wage at the going rate. Thus the final responsibility of the vocational rehabilitation program is assisting the veteran to obtain satisfactory employment—doing that for which he was trained. Shortley has pointed out that "according to the National Manufacturers' Association, 83 per cent of the nation's industries are now employing disabled people in jobs that range from aircraft manufacture and shipbuilding to munitions making and radio repairing, while 26,000 disabled men and women have entered the Federal service in the past sixteen months in the heavy government industries, in professional positions and clerical jobs." Shortley stressed the significant fact that "among the net gains of this experience are the identification of some 3,500 different jobs in which the handicapped can be satisfactorily employed; and employers' discoveries that the handicapped are *not* handicapped at work for which they are suited, with an ability range as great as that of the so-called 'normal' workers." Manufacturers

and industrialists must be brought to the realization of the fact that when properly placed and properly trained, disabled veterans will be an asset to them rather than a liability. You physicians in this great industrial state are in a position to drive home this important information.

This completes my description of a nine-step rehabilitation program for military veterans. I realize that it is a stupendous program which will tax our organizational abilities to the limit. It is also obvious that it will take great effort to co-ordinate the various steps in this program but we must strive with all of our ingenuity to accomplish this very task. I present this program as an objective toward which we should bend all our efforts.

Comment

It has been said¹⁶ that because of my interest in physical medicine, my views with regard to rehabilitation of our veterans "reflect only one of many possible approaches to the problem." I deny this allegation and claim that I have presented the broad viewpoint, perhaps tincturing my presentation with a certain amount of stress on the importance of physical medicine. It must be admitted that psychiatric problems as well as physical problems will be encountered in a high percentage of our disabled veterans, but physical measures play an important part in the rehabilitation of mental as well as physical disabilities and it is only when we have a well-organized physical rehabilitation program that we can restore our mentally or physically disabled veterans to useful citizenship. All of us physicians must become rehabilitation-minded and we must explain to our lay associates what rehabilitation means and how a suitable program can be developed.

In closing, I should like to give you the statement on rehabilitation which was made by John Galsworthy, the English novelist, at the Allied Conference on the After Care of Disabled Men, in Washington, District of Columbia, in 1919. As one of the most illuminating statements ever made on the subject of rehabilitation, I consider it to be a fitting ending for this presentation. Galsworthy said: "Restoration is at least as much a matter of spirit as of body, and must have as its central truth: Body and spirit are inextricably conjoined. To heal the one without the other is impossible. If a man's mind, courage and interest be enlisted in the cause of his own salvation,

healing goes on apace, the sufferer is re-made; if not, no mere surgical wonders, no careful nursing, will avail to make a man of him again. Therefore, I would say: 'From the moment he enters the hospital, look after his mind and his will; give him food; nourish him in subtle ways: increase that nourishment as his strength increases. Give him interest in his future. Light a star for him to fix his eyes on, so that, when he steps out of the hospital, you shall not have to begin to train one who for months, perhaps years, has been living, mindless and will-less, the life of a half-dead creature.'

"That this is a hard task none who knows hospital life can doubt. That it needs special qualities and special effort, quite other than the average range of hospital devotion, is obvious. But it saves time in the end, and without it success is more than doubtful. The crucial period is the time spent in the hospital. Use that period to recreate not only the body, but mind and will power, and all shall come out right; neglect to use it thus and the heart of many a sufferer and of many a would-be healer will break from sheer discouragement. A niche of usefulness and self-respect exists for every man however handicapped; but that niche must be found for him. To carry the process of restoration to a point short of this is to leave the cathedral without spire. To restore him, and with him the future of our countries, that is the sacred work."

If medicine is to assume its rightful place of leadership in the program for the rehabilitation of military veterans, we must not permit our preoccupation with the scientific aspects of our narrow special fields of medical endeavor to prevent us from realizing the extreme importance of intelligent medical guidance in the broader socio-economic problems of rehabilitation. We must give immediate attention to the enormous rehabilitation task which looms before the nation. We must begin at once to think about the contribution which our own particular medical specialties can make toward solution of this impending vast national problem. This time we *must* not fail.

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Obstetrical Hemorrhages

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CLINICAL RESEARCH MEETING

The first regional meeting of the American Federation for Clinical Research was held at the Eloise Hospital on March 10, 1945. One hundred twenty-five men from this state attended. Dr. Gordon B. Myers, professor of medicine, Wayne University College of Medicine, presided as chairman of the program. A dinner meeting followed the scientific program, at which Dr. Cyrus C. Sturgis of Ann Arbor and Dr. Charles McKhann and Dr. Frank Hartman of Detroit were speakers.

ST. MARY'S CENTENNIAL

(Continued from Page 444)

nection with it was built Seton Home to house the hospital laundry and residences for various technicians and clerks. Today, according to Dr. Joinville, the complex variety of services and units typical of the modern hospital are closely co-ordinated into a smooth-running whole, the result of comprehensive reorganization, reconstruction and refitting in 1932.

Today Dr. Joinville looks at St. Mary's and finds it good—but eyes the future for yet more progress. The 1944 figures speak for themselves: fourteen separate clinics in its Outpatient department, 6,393 surgical operations, 150 to 200 babies delivered each month, 1,800 medical cases, an entire wing for Pediatrics, with 105 beds and cribs for children to sixteen, 40,000 clinical laboratory tests annually, new radiology techniques.

Obstetrical hemorrhage may be divided into three main groups: antepartum, postpartum and miscellaneous hemorrhages.

Placenta previa presents special problems in management due to the period of gestation at which hemorrhage occurs, and effect on the baby of normal delivery because of abnormal anatomical relationships between the placenta and uterus.

Premature detachment of the placenta creates special problems because of the damage to the uterine muscle produced in some cases by overdistention.

Postpartum hemorrhage presents a problem in differential diagnosis of the cause of hemorrhage, and application of the proper remedy without undue delay.

Miscellaneous hemorrhages caused by blood dyscrasias, cervical cancer, tears of perineal arteries and cervical polyps are discussed individually.

■ IN recent years there has been a satisfactory reduction in maternal mortality figures in the United States. The two formerly top ranking causes of maternal death in Illinois, sepsis and toxemia, have both been reduced comparatively more rapidly than the hemorrhages so that now these occupy the first position. This has occurred despite the fact that death from hemorrhage is thought to be almost entirely preventable by proper technique in handling this complication of pregnancy. This belief is a fallacy based on the conception that blood loss and its replacement in the vessels constitute the sole problem in management of these cases. In our experience, shock, lacerations, exhaustion and toxemia play almost as important roles as the blood loss itself, and deaths will occur in some cases despite adequate transfusion facilities.

The management of the various forms of hemorrhage which will be considered in this discussion depends on a clear conception of the pathological anatomy of the case under consideration. I will try to point out the principles of treatment which we feel are logical from a consideration of this anatomy.

From the Department of Obstetrics and Gynecology, University of Illinois College of Medicine. Read at the Fourth Annual Postgraduate Conference on War Medicine, the Seventy-ninth Annual Session of the Michigan State Medical Society, at Grand Rapids, Michigan, September 29, 1944.

Placenta Previa

The placenta in these cases is partially or completely over the internal os of the uterus or very close to it. The following chart shows the etiological factors as far as we know them at this time. The primary cause is unknown, but predisposing factors are multiparity, twin pregnancy, endometritis and fibroids. The principal diagnostic points to be looked for in a given case are: painless, causeless hemorrhage occurring in the third trimester of pregnancy.

The cases may be divided into three types:

1. *Centralis*—Bleeds early, recurrently and profusely. Usually observed about seventh month. Placental tissue felt over os. Presenting part is high, confirmed by x-ray.

2. *Lateralis*—Bleeds later and less profusely. Placenta is palpable, partially over os. X-ray shows fetus high.

3. *Marginalis*—Late bleeding, usually slight. Placenta not palpable over os. X-ray reveals the maturity and presentation of fetus and the position of the placenta.

Implantation of the placenta on the lower uterine segment produces a softness and succulence due to increased vascularity in the uterine wall at this point which predisposes strongly to tears of the cervix and lower uterine segment if artificial means are used to bring about dilatation. These changes also interfere with the contractile power of the stretched-out uterine muscle fibers of the lower uterine segment which predisposes to postpartum hemorrhage. The same factors interfere with the response to stimulation by oxytoxics and call for packing the uterus to control bleeding.

In packing a uterus for postpartum hemorrhage in these cases it is important to remember that the bulk of the pack should occupy the lower uterine segment and upper vagina rather than the fundus of the uterus as in other types of postpartum hemorrhage.

The diagnosis of the type of placenta previa, central, lateral or marginal, is important. This can best be done by vaginal examination. The utmost gentleness is required since dislodging the presenting part or further separation of the placenta will cause more bleeding. For this reason Irving has insisted that a vaginal examination should be done in every case, but only after the patient is in an operating room and set up for a

cesarean section in case uncontrollable hemorrhage supervenes. We have not followed this rule and feel that in most cases a rectal examination, if done carefully and gently, will give the desired information, namely, how much dilatation of the cervix is present and whether or not the presenting part is in the pelvis, without producing further hemorrhage beyond what would have occurred due to the condition itself. The size of the fetus and its viability are very important considerations along with whether the patient is a primipara or a multipara. In general, it may be said that the earlier in pregnancy a placenta previa starts to bleed the more apt it is to be a *centralis* type. Unfortunately many of these hemorrhages occur about the twenty-sixth to the twenty-eighth week of gestation. Delivery at this time is almost always associated with fetal death either during or just after delivery. Not infrequently the initial hemorrhage which leads to the diagnosis of the condition is not severe, and stops spontaneously. We are then faced with the unpleasant duty of deciding whether to deliver a baby which will probably not survive or take a chance on a severe secondary hemorrhage jeopardizing the mother and the baby while waiting for the baby to attain sufficient maturity to survive extrauterine conditions.

We feel that the separation of the placenta in these cases is primarily due to the formation of the lower uterine segment which in turn is due in part at least to the increasing strength of the Braxton Hicks contractions. For this reason in a small series of borderline viability cases we have used corpus luteum extract injections to inhibit uterine contractions for a few weeks until we were able to gain a few extra weeks of maturity for the baby. This of course should never be done unless the patient can be kept in the hospital with all facilities for operation in readiness, including complete transfusion preparations.

In the lateral type of placenta previa the choice has to be made between a Braxton Hicks version, Voorhees bag or watchful waiting. These babies are more mature as a rule and a bag induction with a No. 5 bag will usually give sufficient dilatation to permit of delivery of the baby without further trouble. On inflation of the bag it is important to listen to the heart tones because compression of the cord by the bag under these circumstances is not uncommon and may result in fetal death. If the heart tones are seriously af-

ected the bag should be removed and arrangements made for a cesarean section.

In the marginal type of placenta previa the digital examination fails to reveal the placental tissue over the os. In most of these cases the baby is well developed and in good condition. Simple rupture of the membranes will usually suffice to induce into labor and delivery will follow without undue danger to either mother or baby in most cases.

Following delivery from below in all cases of placenta previa postpartum hemorrhage may be anticipated and preparations made to combat it. The percentage of serious hemorrhages is relatively slight.

The use of x-ray for visualizing the position of the placenta in placenta previa has been disappointing in our hands.

Premature Detachment of the Placenta

This is potentially one of the most serious complications of pregnancy. The seriousness of the condition depends on the stage of pregnancy at which it occurs, the degree of separation of the placenta and whether or not the resultant hemorrhage is retained within the uterus or finds ready access to the vagina.

A premature separation of the placenta in the first five months of pregnancy results in extrusion of the product of conception with practically no serious bleeding and is ordinarily diagnosed as an abortion or miscarriage.

Partial separation of the placenta with apparent hemorrhage is quite common and is frequently mistaken for placenta previa. In fact it is very much like the marginal type of placenta previa. Usually, however, with this condition there is some pain with the bleeding and uterine contractions are frequently stimulated. The heart tones may or may not be affected depending on the amount of separation which is roughly proportioned to the amount of blood loss. If the separation is slight we keep the patient under strict observation even if the bleeding stops completely. Frequently these cases will go on to term, and when the placenta is delivered old organized blood clots mark the place where the placenta was detached. If bleeding continues or the heart tones become rapid or weak a cesarean section is indicated.

Complete separation with apparent hemorrhage furnishes another group of cases. In these the

hemorrhage is much more massive, the fetus dies and the condition of the mother corresponds to the visible blood loss. If the accident occurs before the woman goes into labor the best solution is to deliver by cesarean section. If she is well along in labor the dilatation of the cervix should be completed manually and the baby delivered by forceps if the head is engaged or by version if not.

Complete detachment of the placenta with concealed hemorrhage produces pathology which is most serious and in this group of cases most of the maternal deaths occur. Under these circumstances the uterus enlarges, becomes of ligneous consistency and the muscle fibers are disrupted by blood clots resulting in the utero-placental apoplexy of Couvelaire. Because of these changes the uterus in these cases may be incapable of responding by contraction to any stimulus such as massage, packing or oxytocics and hence a fatal postpartum hemorrhage is superimposed on the antepartum blood loss. In these cases the patient complains of severe continuous pain, presents the clinical picture of shock and hemorrhage out of all proportion to the amount of apparent blood loss. We believe that under these conditions a cesarean section under local anesthesia is indicated, followed by hysterectomy if the uterus fails to respond to the injection of pituitrin given just before the uterus is opened.

Occasionally, a patient with concealed hemorrhage and a Couvelaire uterus will dilate the cervix partially and expell much of the intrauterine blood. Under such circumstances, the uterine wall may remain as a thin, flabby sac into which marked bleeding occurs unless a hysterectomy is promptly done. These patients are not good surgical risks but the prognosis by any other treatment is worse. Replacing blood loss and full stimulation. Trendelenburg position and binding the limbs are indicated.

Postpartum Hemorrhages

The most common cause of postpartum hemorrhage is atony of the uterine muscle fibers. Overdistension is the most common cause of this atony and may be due to hydramnios, long hard labor, multiple pregnancy, or degenerative changes in the uterine myometrium. It is often accompanied by shock and lacerations of the birth canal.

The possibility of postpartum hemorrhage

should always be kept in mind, and an adequate defense should be available in all labor cases. As soon as a fetus is delivered, the fundus of the uterus should be palpated, and if not contracting it should be massaged until it does contract, and ergot and pituitrin should be administered hypodermically. Blood loss over 500 c.c. should be considered a hemorrhage and treated accordingly. Smaller amounts may cause serious complications also in anemia patients. A uterine pack should be at hand and the uterus packed if it fails to stay contracted.

Technique of Uterine Packing

The pack is held to the left of the operator in a sterile jar. The left hand is inserted into the uterus and the clots are removed. The left hand is then filled with gauze and this is carried to the fundus of the uterus and tightly packed against it. The hand is withdrawn and refilled with gauze and the packing maneuver repeated until the whole uterine cavity is distended with gauze. The vagina may also be packed in severe cases or where there is bleeding from lacerations or ruptured varices. If more than 1,000 c.c. of blood has been lost before the pack is inserted we usually wet it with weak lysol solution and leave it in for 48 instead of the usual 24 hours.

If the hemorrhage continues after the uterus has contracted down it indicates that the bleeding is coming from some other source than the body of the uterus. In such cases the cervix must be pulled down and inspected and all tears sutured with interrupted stitches. Vaginal tears are likewise sutured and bleeding points exposed by inserting a tailed sponge which holds back blood from the uterus.

Occasionally a deep artery is torn in the perineum which may give rise to a deep hematoma. These appear as large tumefactions on the perineum to one side of the rectum and extending upward under the mucosa of the vagina. They may be so large that the vaginal tube is almost closed. If seen early in the formative stage these hematomas may be controlled by pressure. If they attain considerable size they may have to be evacuated and the bleeding point tied off.

Retained placenta is a frequent cause of postpartum hemorrhage. In these cases the afterbirth is partially detached, but will not come away because of unusual attachment of one portion.

In some cases on investigation of the interior of

the uterus, it will be found that an arcuate type of bicornuate uterus is present and that the placenta is attached in one or the other horn. When this situation presents itself the patient is redraped and scrubbed, gown and gloves are changed. The left hand is inserted into the uterus and the placenta peeled off by inserting the fingers between the uterus and the adherent portion of the placenta.

Occasionally a small piece of placenta or a succenturiate lobe of the placenta may be retained in the uterus without causing hemorrhage immediately after the birth of the baby but bleeding may come on several days later. This is most unfortunate since it often means another trip to the hospital, with arrangements to have the baby cared for while the mother is away from home. Nevertheless, the best procedure is to bring the patient back to the hospital, anesthetize her and remove the placental tissue with an ovum forceps or curette followed by ergot for a few days.

Postpartum hemorrhage may be associated with rupture of the uterus. This accident may or may not be suspected before the birth of the baby. Whenever such suspicion exists prompt investigation of the genital tract should be undertaken. The patient is rescrubbed, the physician changes gown and gloves. The left hand is carried up through the cervix and lower uterine segment. If the uterus is contracted the musculature of the body of the uterus will feel like a doughnut, the cavity of the uterus representing the hole in the doughnut. Just below this is the looser lower uterine segment and the rupture will be found here. By sweeping the fingers of the left hand around the lower uterine segment a defect will be found. A pack is placed tightly in the lower segment and the upper vagina, and the patient taken to the operating room at once for a supra-cervical hysterectomy.

Occasionally with a pendulous abdomen the forces of labor cause a thinning out and tearing of the vagina where the posterior wall attaches to the cervix (colporrhexis). This is practically the same as a ruptured uterus, although the hemorrhage is not so severe as a rule. The same treatment is necessary.

Other causes of vaginal bleeding may be cervical polyps which rarely bleed profusely, and which can be cauterized off at any time during the pregnancy. Very rarely bleeding of a similar nature may be due to cervical carcinoma. The

cervix of pregnant women is not frequently visualized on routine prenatal examination, and as a result the rare cases of carcinoma and pregnancy are overlooked. Hemorrhage from this source should be treated by hysterectomy if discovered in early pregnancy and by cesarean section if late, followed by radium and x-ray intensive treatment. The prognosis is not good.

Another rare cause of vaginal bleeding is rupture of the membranes when a vasa previa exists. The ruptured fetal vessels pour fetal blood into the vagina, this is mistaken for maternal blood and a diagnosis of placenta previa is usually made. Staining this blood and finding nucleated red blood corpuscles would be suggestive of the diagnosis.

In all forms of obstetrical hemorrhage the watchword should be "be prepared." Patients who have a bad history of repeated hemorrhage after delivery should be brought into hospitals for care. They should be typed and cross matched. Donors should be requested to be available. The Rh factor should be studied. Plasma should be on hand and, failing these, glucose, saline and acacia solutions can always be made available.

The amount of blood lost by any woman in childbirth should be minimized by (1) the proper conduct of the third stage of labor; (2) prevention of exhaustion and dehydration during long labors; (3) routine use of pituitary extract and ergotrate after birth of the baby; (4) careful limitation of blood loss by massage, drugs and packing as soon as it becomes evident that there is a tendency to bleed. After a certain point in a postpartum hemorrhage, the coagulability of the blood is seriously impaired. (5) See to it if possible that every patient who goes into labor has a high red cell and hemoglobin count, even if transfusion has to be resorted to to attain them. A small hemorrhage can result fatally in an anemic mother. (6) Vitamins K and C should be given in adequate doses where there is any evidence of defect of the coagulation mechanism.

Death from hemorrhage is now the most common cause for maternal mortality in Illinois. Since many of these deaths are preventable it seems to me that an all-out effort should be made by the medical profession to minimize these deaths. The possibilities of supplying dried plasma to doctors and hospitals in the rural areas has

not been exhausted. Blood banks are becoming more plentiful. People have been educated to donate blood to bleeding cases and should be further encouraged to do so.

I think this is a problem for state action. In North Dakota they have a plasma bank established by law, and under the guidance of the medical profession. The processing of the blood is done at and by the State University, and the bill is paid by state taxation. Co-operation of the various parties to the contract, doctors, patients, medical societies, Universities, will bring, if properly directed, results in the future not dreamed of in the past, and a record of which we may all be proud.



RISK OF INFANTILE PARALYSIS NO GREATER IN ARMY THAN CIVILIAN LIFE

Despite the huge concentration of men brought together from all parts of the country in Army posts and the combat conditions under which great numbers are living, there is apparently no more danger in the Army from infantile paralysis than there is in civilian life.

The Office of The Surgeon General reports that the number of cases was 3.4 per 100,000 troops in this country in 1943 and 4.0 in 1944. The case fatality rate was 12.1 per cent in 1943. This is similar to the civilian rate for similar ages, and there is a further similarity in the time of year the cases occurred and their geographical location.

There has not been an epidemic of infantile paralysis at any Army post during this war.

ARMY ACHIEVING SPEEDY EXPANSION OF HOSPITALS

The Army's expansion of its general hospitals by 70,000 beds is being rapidly accomplished through the conversion of existing buildings on hospital grounds rather than through new construction, according to the Office of The Surgeon General.

"At many of the general hospitals," said Brigadier General Raymond W. Bliss, USA, Assistant Surgeon General, "there are well-constructed barracks, built with an eye to the future, which were used to house overseas hospital units during their training period. These barracks are now being turned into wards for patients. Permanent barracks, built to house the hospital staff, are also being converted into wards and are being replaced with temporary barracks which can be quickly constructed."

Over 50,000 more patients are being cared for in the Army's general hospitals than was the case three months ago. During the past month about 1,200 casualties arrived from overseas daily.

Editorial

THE NEXT STEP

■ WE HEAR plans and projects for the return to normalcy.—There will be reconversion and happy lives. These are dreams, pleasant, good and needful, but remember we are not going back to anything. The world of the past, the prewar world is gone. The world of the future will be what we make it. And in that making the minds and experiences of all will determine the final result. Every effect has a cause, and it is up to our thinking people to stimulate and guide the causes so that the result may not be too unwanted. Our profession is a part of the organic whole, and will be governed by the same basic philosophy.

The medical profession has never gone back. It has always progressed to an era of greater service. There have been times when the progress was unseemly slow, but history proves the inevitable and eventual progress. In the past there were many reason for making progress slowly. The level of general education of the world was low, methods of study, research and communication were slow. There were giants in the profession but their means of advancement and communication were meager, ideas could barely grow, and we were in the stages of civilization where everyone must of necessity gain his experience the hard way, by personal efforts.

Times have changed. We now use our brains and minds for experience, profiting by the studies and experiences of others, and building from that vantage. The result is a world of complex civilization, but of ever-increasing knowledge, and far-reaching advances in the realm of medicine. More and more of the members of our profession have added to the store of available learning, until now the resources of the physician when he ministers to his patients is almost beyond belief.

Many of our members have foreseen the changing times in the world, with more complex medical problems, more means and methods to care for the ailments of the sick, and consequently the rising costs of adequate medical care. Years of study have pointed the way to evolving solutions. Labor and the lay public have been impatient and met this problem with demands for more

satisfactory guarantees of security. Both groups have hit upon the insurance principle as a probable means of solution. The Michigan Medical Profession has produced a satisfactory, workable prepayment voluntary plan. Labor and those upon the receiving end have demanded protection, and have suggested compulsory insurance. Social workers and bureaucrats have seized upon the principle of government control and compulsion, but have failed to meet the whole problem. They have offered an attractive but unworkable package. They have failed to consult the very people whom they insist must render the services under their direction.

The first and unfortunate reaction of the profession was one of opposition. They were dazed by the audacity of the plans, and the inadequacy of so many features of them. Being scientific men accustomed to working on solid foundations, they could not offer advice or plans, because there was no experience upon which proper plans could be based.

Michigan took steps to find the remedy, and has what we have demonstrated is a satisfactory plan. Other states have made similar studies and have arrived at the same conclusions. Nationally the profession has not yet reached the same advancement. Nationally the attitude is still largely one of opposition to what is being offered and skepticism of what some states have demonstrated. Michigan believes we have reached the stage where something constructive must be forthcoming, or the bureaucrats will attempt to take over, and with their inexperience and expensive methods try to guarantee to all complete medical care on a compulsory basis.

Our survey of public opinion shows a small number of the public actually wanting government bureaucratic medicine (15.5 per cent) and a very considerable number in favor of plans sponsored by the profession that best knows how to care for the sick (33.7 per cent). Michigan's Medical and Hospital co-operative plans, however, were completely unknown to 75.4 per cent of the people. Our job is to make the public acquainted with what is available now for their welfare. The chairman of a study group in one

(Continued on Page 496)

The Value of the Work Done



President's



Page



As Brunk

President, Michigan State Medical Society

Born of the great depression was the magnanimous philosophy of giving medical service to governmental agencies—especially for indigent groups—at cost, or in many sections, at less than cost. This generosity on the part of the medical profession has persevered through the lean up to the present fat years, during all of which time government paid and is paying a uniform fee on all other commodities based on their value. It buys food and fuel and other necessities—for indigents—at no 50 per cent reduction but at their market value. Other purveyors must live.

In the light of modern conditions, changes and trends, and the creation of new categories and great groups of governmental wards, the Michigan State Medical Society has decided that medical service shall be rendered on an equitable fee basis, commensurate with the value of the work done rather than to whom rendered.

Postwar governmental categories—all wards of the State—will be greatly multiplied and will constitute a large segment of private practice. Therefore, the philosophy of selling to government its commodity of service at less than cost must be withdrawn by the medical profession if it hopes to survive, especially during the retrogressive days to come.

A Committee of the Michigan State Medical Society is now developing a uniform fee schedule for governmental agencies—a schedule which will consider living costs, geographical variables, and all other factors. When this schedule is announced, the unified co-operation of the medical profession in placing it into operation throughout the State will be necessary and is here urged.

(Continued from Page 494)

of our larger cities last month actually reported that there was no available services for prepayment medical care and therefore the Wagner-Murray-Dingell Bill must be supported. This chairman had never heard of Blue Cross and the Michigan Medical Service. Every effect has a cause, and this effect is due to inadequate salesmanship. It is our very existence as an independent profession that is at stake, and it is the combined efforts of *all of us* that will determine what the outcome will be. We are not going *back*, we are going onward, but to what? Something better? Something worse? It is for you to say.

STATE MEDICINE IN MICHIGAN

■ A BILL for statewide compulsory health and hospital insurance was introduced by Representatives Carey of Detroit and Kenny of Flint on April 5, 1945. The bill has not been printed at this writing, but it is entirely clear that this measure is a counterpart of recent Federal plans for the complete control of all health services, including medicine, dentistry, nursing and hospitalization by a proposed state agency to be known as the Michigan Health Insurance Commission.

The bill calls for all employers and employees to contribute 1.5 per cent of each employee's salary to the state health insurance fund, including all salaries up to \$5,000 a year. A seven-member health commission is proposed, consisting of two representatives each of labor, employers and the medical profession, the seventh to represent the general public.

Administration is proposed by an executive director at \$15,000 a year, a medical director at \$12,000, and area directors at \$10,000 each. The proposed commission is charged with the responsibility to see that the beneficiaries get the services they desire. It will have authority to cooperate with the Federal Government in a similar national health insurance plan.

Close study of the bill has not been possible, but there can be no doubt that this proposal is the most direct challenge to the profession ever attempted in any state, not excluding California.

This action was anticipated by the Executive Committee of the Council, Michigan State Medical Society at its February 21, 1945, meeting

when the Chairman was directed to appoint a Drafting Panel to study the medical profession's desires in socio-economic endeavor for possible subsequent submission to the federal legislative body. Meantime the legislation in Michigan must be considered as a real step toward state medicine.

OBTAINABLE MEDICAL SERVICE

■ About a month ago a news article appeared in one of the cities of Michigan stating that a baby died of choking because the mother tried to call seven doctors before she could get one to come. The child was finally sent to the hospital, relieved, and put to bed. A few hours later another attack occurred and the baby died before tracheotomy could be done. One of the metropolitan papers copied the item and advertised the seven doctors' calls further. Neither paper told of the care rendered.

About the same time, one of our busy practitioners in a smaller city referred one of his pregnant patients to a certain doctor in a city to which the family was moving. The patient tried to call this referred doctor but he was too busy on another case to take any more work. The time of confinement came and no doctor could be secured. The home doctor was called, and made the fifty-mile trip, delivered the baby, collected his cash fee, and returned to his own home.

Such are the occurrences which prompted 5.8 per cent of the people to tell the Michigan Health Council in its survey that doctors were neglectful of their patients. This minority group throw most unfavorable publicity on the whole medical profession (the other 94.2 per cent).

In attempts to secure certain medical care for all who need it, and have not established satisfactory arrangements with a family doctor to whom they may turn with assurance, the Wayne County Medical Society has a twenty-four hour medical information service at its headquarters building, David Whitney House, which refers all calls to returning war veterans if they will respond, then refers excess calls to other members of the Society. Calhoun County Medical Society has a committee working on this same question in an attempt to guarantee that all calls are answered. Kalamazoo Academy of Medicine has one of its members on night duty at one of the hospitals every night to answer just such

calls. This service is in rotation, and all members take their turn.

During the present time of stress with older and retired doctors carrying much of the burden we are inclined to refuse calls, and must, in fact, postpone some of them if we are to keep on with our work. After all, a Doctor of Medicine requires some sleep. But there is a time coming when we shall have our servicemen back and will not be so rushed. Then we shall be glad of these calls that we are tempted to beg off. The cultists are wiser and are not refusing calls. Do they see into the future?

NEW BENEFITS FROM YOUR PLAN

■ MICHIGAN Medical Service, the voluntary group medical care program sponsored by the Michigan State Medical Society, is in the black. This feat in medical economics was accomplished in five years' time. Michigan Medical Service has paid off all debts and now has a modest surplus.

Consistent with its purpose of granting extended benefits to subscribers whenever able to do so, Michigan Medical Service has announced an increase in surgical benefits covering a number of additional services at no increase in rates. The new benefits were effective April 1, 1945, and are listed on page 434.

Be a booster of Michigan Medical Service. It is *your* plan. *Your* plan is far better for your patients and for you than any compulsory program conceived, controlled, and administered by government bureaucrats!

AN UNWISE RECOMMENDATION

■ A program which would carry on after the war and extend work somewhat similar to that done currently by the EMIC has been recommended to the Children's Bureau by its Steering Committee on Health Services.

One of the seven recommendations is: administration of crippled children's program by state health departments.

The Michigan program for crippled children has been outstanding. Since 1927, when crippled children legislation was enacted, thousands of crippled individuals have been given service, and the present administration of the program by the Michigan Crippled Children Commission deserves high praise. Few persons in this State

would favor the abolition of the Crippled Children Commission with its high grade personnel and fine record of service. The Commission and its Medical Director have handled the touchy problems of care of crippled and afflicted children with understanding and diplomacy. They have become specialists in the art of co-operation. They have never lost the human touch or forgotten that curative medicine is the domain of the practitioner.

Health departments are at their best in the advancement of preventive medicine for which they were created. Their forced advent into the field of curative medicine—such as in the poorly conceived and badly bungled EMIC Program—neither adds to their laurels nor to their peace of mind.

The medical care of crippled children is not a proper function of a state health department. We doubt the wisdom of the Children's Bureau's so-called Steering Committee in making this recommendation; at least it would be unwise so far as Michigan is concerned.

ON THE RUN . . .

In liver necrosis due to protein deficiency the right half of the liver may suffer less damage than the left because it is supplied mainly by the superior mesenteric vein which carries the products of protein digestion.

• • •

Beware the innocuous gunshot wound of the buttock with little disturbance of the patient. Perforation of pelvic organs may be present.

• • •

Every patient confined to bed, who is not suffering from an acute infection, should have daily massage to the lower limbs unless there is any lesion in the limbs themselves.

• • •

Ducks may suffer from epidemics of salmonella infections and their eggs may harbor the infectious organism in the yolk.

• • •

Patients over fifty, suffering from arterial deficiency, are more liable to venous thrombosis and probably embolism as well.

• • •

Anticoagulant therapy with heparin or dicoumarol will not improve the blood supply of tissue after the blood vessels supplying it have been occluded.

• • •

Queer results of today's paper shortage: scant scientific publications, abundant and elaborate direct mail circulars.

Selected by W. S. REVENO, M.D.

Annual Reports

SECRETARY'S ANNUAL REPORT—1944

By L. Fernald Foster, M.D., Bay City

I herewith submit the report of the Secretary for the year 1944, the third report of World War II.

Membership

The Society's membership is now relatively stationary in this the third year of the war. Few practicing physicians joined the armed forces during 1944 and obviously few new physicians have been available for membership.

In 1944, there was a total of 4,702 members, including fifty-eight Emeritus, Honorary and other Special Memberships, and 1,151 Military Members. The total paid memberships were 3,493 with net dues of \$36,480.39 accruing to the Society.

The number of members with unpaid dues in 1944 was eighty-nine. The membership tabulation for the

Presented to the Council, MSMS, in Annual Session, Detroit, January 26, 1945.

years 1943 and 1944 showing net gains and losses, unpaid dues, and deaths is shown in the accompanying table.

Deaths During 1944

**Died in Military Service*

We regretfully record the deaths of eighty-two members during 1944. Among these is the death of our President-Elect, Vernor M. Moore, M.D., who passed away on December 30, 1944. The list tabulated by counties is as follows:

Bay County—C. W. Ash, M.D., Bay City; Charles H. Baker, M.D., Bay City; Charles M. Swantek, M.D.
Berrien County—J. U. Allen, M.D., Benton Harbor.
Calhoun County—Charles C. Landon, M.D., Battle Creek.
Delta-Schoolcraft County—Harry W. Long, M.D., Escanaba; James D. Mitchell, M.D., Gladstone.
Eaton County—H. A. Moyer, M.D., Charlotte; Vinton J. Rickard, M.D., Charlotte; C. S. Sackett, M.D., Charlotte.
Gogebic County—Wm. Elwood Tew, M.D., Bessemer.
Houghton County—R. S. Buckland, M.D., Baraga.
Ingham County—C. S. Davenport, M.D., Lansing; R. H. Phillips, M.D., Lansing; H. B. Weinburgh, M.D., Lansing; J. T. Warford, M.D., Lansing.
Ionia-Montcalm County—A. J. Bower, M.D., Greenville.

MEMBERSHIP RECORD, 1944

County	1943	1944	Military	Loss	Gain	Unpaid	Deaths
Allegan	19	19	3				
Alpena-Alcona-Presque Isle	10	12	6		2		
Barry	9	10	4		1		
Bay-Arenac-Gladwin-Iosco	49	49	26				4
Berrien	52	49	11	3		5	1
Branch	13	15	7		2		
Calhoun	75	69	39	6		3	1
Cass	12	12				1	
Chippewa-Mackinac	16	16	7				
Clinton	10	10	3				
Delta-Schoolcraft	19	17	5	2			2
Dickinson-Iron	15	16	5		1		
Eaton	20	15	6	5			3
Genesee	141	142	48		1	3	3
Gogebic	19	17	2	2			1
Grand Traverse-Leelanau-Benzie	32	30	10	2		1	
Gratiot-Isabella-Clare	27	26	12	1		2	
Hillsdale	20	20	6				
Houghton-Baraga-Keweenaw	32	31	8	1		1	1
Huron	11	11					
Ingham	127	128	38		1	14	4
Ionia-Montcalm	30	32	9		2		1
Jackson	75	72	26	3			2
Kalamazoo	73	76	44		3		5
Kent	191	181	77	10		1	9
Lapeer	10	12	3		2		
Lenawee	29	26	14	3		1	2
Livingston	12	14	5		2		
Luce	8	7	3	1			2
Macomb	34	28	10	6		6	
Manistee	9	8	3	1			
Marquette-Alger	30	28	8	2		3	1
Mason	10	7	3	3		1	2
Mecosta-Osceola-Lake	12	12	3				1
Med. Soc. of No. Cen. Co's.	13	12	2	1			
Menominee	9	9	3				
Midland	14	15	2		1		
Monroe	27	26	11	1			1
Muskegon	61	63	19		2		3
Newaygo	10	9	2	1			1
Northern Michigan	31	28	5	3		1	2
Oakland	111	114	43		3	2	2
Oceana	9	9	3				
Ontonagon	5	4	1	1			
Ottawa	26	22	5	4		2	1
Saginaw	71	68	32	5		3	1
Sanilac	11	11	2				
Shiawassee	16	14	11	2		1	2
St. Clair	46	46	6				1
St. Joseph	16	14	9	2		1	
Tuscola	23	21	4	2			1
Van Buren	20	20	8				
Washtenaw	155	157	49		2	4	
Wayne	1,634	1,596	474	38		32	22
Wexford-Missaukee	20	18	6	2		1	
	3,579	3,493	1,151*	111	25	89	82
	3,493						
	86						

*This total of 1,151 Military Members includes five who died in 1944.

ANNUAL REPORTS

Jackson County—Peter A. Scheurer, M.D., Manchester; F. S. Tuthill, M.D., Concord.

Kalamazoo County—Ervin D. Brooks, M.D., Kalamazoo; J. T. Burns, M.D., Kalamazoo; F. M. Ilgenfritz, M.D., Kalamazoo; Rush McNair, M.D., Kalamazoo; H. A. Sears, M.D., Kalamazoo.

Kent County—*Martin Batts, M.D., Grand Rapids; C. J. Geenan, M.D., Grand Rapids, O. H. Gillett, M.D., Grand Rapids; Thomas C. Irwin, M.D., Grand Rapids; Jacob E. Meengs, M.D., Grand Rapids; Vernor M. Moore, M.D., Grand Rapids; Wm. Northrup, M.D., Grand Rapids; Wm. H. Veenboer, M.D., Grand Rapids; John M. Wright, M.D., Grand Rapids.

Lenawee County—C. W. Case, M.D., Onsted; A. C. Wood, M.D., Adrian.

Luce County—Frank P. Bohn, M.D., Newberry; Charles B. Toms, M.D., Newberry.

Marquette-Alger—Wilfred S. Picotte, M.D., Ishpeming.

Mason County—Wm. H. Force, M.D., Ludington; C. M. Spencer, M.D., Scottville.

Mecosta-Oscoda-Lake County—James B. Campbell, M.D., Big Rapids.

Monroe County—Wm. A. Smith, M.D., Petersburg.

Muskegon County—C. M. Colignon, M.D., Muskegon; George L. LeFevre, M.D., Muskegon; *Bertram W. Morse, M.D., Whitehall.

Newaygo County—*Lewis J. Geerlings, M.D., Fremont.

Northern Michigan—John H. Gilpin, M.D., Cheboygan; Wilbur F. Reed, M.D., Cheboygan.

Oakland County—C. A. Mooney, M.D., Ferndale; A. V. Murtha, M.D., Pontiac.

Ottawa County—S. L. DeWitt, M.D., Grand Haven.

Saginaw County—R. R. McGregor, M.D., Saginaw.

Shiawassee County—C. A. Crane, M.D., Corunna; *H. J. Kaufman, M.D., Owosso.

St. Clair County—Theodore F. Heavenrich, M.D., Port Huron.

Tuscola County—U. G. Spohn, M.D., Fairgrove.

Wayne County—Harry S. Berman, M.D., Detroit; Andrew P. Biddle, M.D., Detroit; Ferdinand Chenik, M.D., Detroit; Edmund F. Collins, M.D., Detroit; Wm. M. Donald, M.D., Detroit; E. A. Drolshagen, M.D., Detroit; A. W. George, M.D., Detroit; Wm. C. Hawken, M.D., Detroit; Robert Laird, M.D., Detroit; Michael Wm. Lash, M.D., Detroit; *Herman M. Lord, M.D., Detroit; George L. Lowry, M.D., Detroit; E. J. Lynch, M.D., Detroit; *William G. Martin, M.D., Detroit; George H. Palmerlee, M.D., Detroit; Wm. A. Repp, M.D., Detroit; J. W. Scott, M.D., Detroit; *G. A. Skully, M.D., Detroit; *Joseph E. Sliady, M.D., Northville; Charles R. Sheridan, M.D., Detroit; J. N. Swartz, M.D., Detroit; Alexander L. Turner, M.D., Detroit.

Financial Status

The books of the Michigan State Medical Society were audited on December 31, 1944, by Ernst and Ernst. Their published report reveals the following financial conditions: Assets are listed at \$98,117.96, and are \$35,862.72 more than a year ago. The net worth is \$43,603.13 compared to \$28,639.95 in 1943. The income from dues was \$36,480.39, with a JOURNAL income of \$7,919.39, interest of \$1,100.03 and miscellaneous receipts of \$101.26 or a total income of \$45,601.07, an increase of \$4,518.35 over 1943.

The Society expenses totaled \$30,587.89 which shows a net gain of \$14,963.18 in the operation of the Society for the fiscal year 1944.

The security portfolio consists of high grade bonds, approximately 50 per cent of which are in U. S. Savings and War Bonds. The securities on December 29, totaled \$47,092.28, represented as follows:

Securities held by the society.....	\$29,528.25
Securities held by the Postgraduate Medical Education Foundation.....	\$17,564.03

Interest received on securities during the year was \$839.20.

The Postgraduate Medical Education Foundation shows a balance on Dec. 29, of \$18,210.56 as compared with \$9,356.84 one year ago. This increase was due largely to contributions received from the Andrew P. Biddle estate.

The Public Education Fund created by the 1944 \$10.00 assessment per member amounted to \$34,480.50. The balance in this fund on December 29 was \$13,363.77.

The Journal had allocated to it from member's dues \$5,211.61. Other incomes were from subscriptions, reprint sales, advertising sales, and JOURNAL cuts, making a total income of \$28,265.06. The expenses included the Editor's salary and expense amounting to \$2,100.00, printing and mailing of \$12,962.57, and these with other relatively small expenses made a total of \$20,345.67. The income was \$7,919.39 over expenses.

Medical Defense Funds showed a balance in December, 1943, of \$3,572.92. Interest in the amount of

\$217.50 and profit from the sale of securities of \$377.50, makes a total of \$4,167.92.

Expenses amounted to \$866.02, leaving a trust balance on December 29, 1944, of \$3,301.90, a decrease of \$271.02.

Summary.—The financial statement of the auditors is complete in every detail of the Society's wartime position. With approximately 1,200 members in the armed forces the impact of war in this one instance reflects, through the remission of dues, a loss of income of nearly \$15,000.00 per annum.

The 1944 Annual Session

The Annual Meeting was held in Grand Rapids in September, 1944, and a total registration of 1,449 was recorded. Considering the number of members serving in the armed forces, the restrictions on travel, and the demands made upon the practitioners at home, the attendance in an out-state city was very gratifying.

The General Assembly type of Scientific Program with daily Discussion Conferences was continued and met with the usual popular approval.

A Modest Scientific Exhibit, consistent with available display facilities, was held. The scientific exhibits were all sponsored by medical organizations or institutions.

The policy of bringing to the Scientific Assembly out-of-state essayists of national and international reputation was continued, and no expense was spared in making the meeting as interesting and attractive as possible. Despite the unusually great expense incurred in maintaining the high standard of the Michigan Session, a substantial profit accrued to the Society as a result of the very large and splendidly developed technical exhibit. The registrants at the Convention showed their usual appreciation to the technical exhibitors and gave them a generous portion of their time.

County Secretaries' Conferences

Two conferences of County Secretaries were held in 1944. The January Conference held in Detroit was a "School of Information" and was devoted largely to Public Relation subjects. It was the largest conference of its kind—with an attendance of over 200.

A second conference was held in Grand Rapids in September at the time of the Annual Session. This conference was attended by over 100 secretaries and other officers and delegates.

Both conferences were highly successful and elicited much favorable comment from the registrants.

Committees

Despite the many demands being made upon all the home-front practitioners, it is interesting to report that the Committee activities of the State Society were maintained at a prewar level of efficiency and enthusiasm. It is impossible to devote sufficient time and space to detail the activities of each committee. Many of the committees have been developing long-range programs, and the effects of such planning is becoming increasingly apparent as their projects continue to mature.

A perusal of the minutes of all the committee meetings during 1944 would elicit an appreciation of the tremendous contribution of time and effort made by the many members of the State Society to the development of its many splendid projects.

Society Activities

Considering the difficulties of developing programs, together with restrictions on travel, some county societies have found it necessary to hold fewer meetings, while many have utilized the extramural postgraduate conferences as regular society programs.

Contact with the fifty-five county units has been maintained throughout the year by regular Councilor and Officer Visitations and by the issuance of seven "Secretary's Letters." Of these, four were sent to County Society

ANNUAL REPORTS

Presidents and Secretaries and three were sent to every member of the State Society.

The State Society should point with pride to the various innovations and achievements of the past year. It was during 1944 that Michigan Medical Service emerged from a condition of questionable solvency to one of financial stability. A deficit of over \$500,000.00, reported in 1943 was completely liquidated during 1944. The corporation is now adding to its 750,000 subscribers at the rate of 15,000 a month and developing reserves at the rate of \$30,000.00 a month.

It was the Michigan State Medical Society which in 1944 sponsored the development of Michigan Health Council and is now one of its four participants.

1944 saw the completion of a Survey of Public Opinion in Michigan, a device designed to aid the Society in developing projects and programs consistent with the wishes of the Michigan public.

The sum of \$10,000.00 was spent in 1944 for Commercial Radio Broadcasts—a program designed to enhance the good Public Relations on the medical profession in Michigan.

Evidence of progressive alertness on the part of Michigan physicians was evidenced by the organization of the Michigan Physicians Committee, a branch of the National Physicians Committee.

The 1944 House of Delegates registered its approval of the Public Education programs of the Society by again authorizing the assessment of \$10.00 upon each member in 1945 to continue and enlarge its programs of Public Relations. It also demonstrated its vision of postwar needs by authorizing a Postwar Medical Veterans Readjustment Program for returning physicians; it implemented this program with a \$5.00 per member assessment.

The members of the State Society now enter upon another year of activity which promises to present to the profession even bigger problems. The physicians on the homefront with depleted ranks have a responsibility to carry on the civilian practice of medicine and to preserve the fundamental traditions of American Medicine. Too few physicians seem to realize that a crisis is impending in medicine. There seems to be an undeniable need for a modification of the present methods of providing medical care—a need which can only be met with a positive attitude on the part of organized medicine. Its time-honored negative attitude—inherited from its parent organization—can only spell disaster.

This State Society has pioneered in positive attitudes. It has blazed a trail in prepayment medical care plans; in State Society Public Relations it has developed programs and mechanics which have been a guide for many states.

Progressive Michigan Medicine strives for better things in behalf of the people it serves. It does not and cannot rest on its laurels. It seeks to develop greater progress and to give greater leadership.

Recommendations

In conclusion, I respectfully recommend that during 1945 a greater effort be made toward the development of better "Public Relations" and more "Public Information" and that the medical postwar problems be anticipated and suitable provision made for their solution.

Also that in view of the large number of our members in the armed forces, who have a vital interest in the profession and their colleagues at home, that a periodic *News Letter* be sent by the Society to all these members. Such a letter could contain various items of a personal and newsy character.

In order to avail itself to the experience and counsel of the President and in order to enhance the continuity of the various society projects, I recommend that the immediate Past President be officially invited to all meetings of The Council and its Executive Committee for one year following his term of office.

Your Secretary desires to express to this Council and the administrative personnel his sincere appreciation of

their fine co-operation during 1944; and to the committees of the Society a hearty commendation of their splendid efforts in the successful execution of many fine and original projects.

To Mr. Burns for his wise counsel and advice, to the office personnel for their splendid and willing co-operation, and to all those who have aided so generously in the discharge of the duties of this office—your Secretary is most grateful.

EDITOR'S ANNUAL REPORT—1944

By Wilfrid Haughey M.D.

Battle Creek, Michigan

THE JOURNAL of the Michigan State Medical Society has published 1,134 pages, exclusive of the four cover pages each month. Paper shortages and difficulty with sufficient labor have prevailed, but the standards and appearance of THE JOURNAL have been maintained. There has been unavoidable delay in the last two numbers which we hope will be corrected very soon. These were labor difficulties, largely, though part of the delay in our December number was in the mail, taking a week to deliver many of those JOURNALS.

During the year we have published sixty-eight original articles which we consider of unusually good quality. We have tried to publish the picture of the author with each paper, believing that adds interest for the reader. Forty-five editorials have been published this year in an effort to keep the profession informed as to medical trends, economic conditions, and the progress being made in Michigan to meet these changing ideologies. We have tried to interpret the instructions and policies of the House of Delegates and The Council to our readers, and we have attempted to suggest a program to guide us through unusual times of stress and difficulty.

One hundred and one books have been reviewed in our Doctors' Library Department. In making these reviews we have tried to make them short and give the reader a concise picture of the usefulness of the book. Notes have been prepared of 68 deaths of our members and of Herbert Barbour, the legal advisor for our society for many years. These deaths include Charles H. Baker, Andrew P. Biddle, and George L. Lefevre, who served the society as presidents and members of The Council rendering scores of years of useful service to the profession. To these names should be added John Harvey Kellogg who wrote medical history in Michigan for nearly three quarters of a century. To scan the list makes one appreciate that these and the others of our departed members in their going have left great voids in our ranks and have passed on to their successors memories of years of devotion and service.

The financial report on THE JOURNAL for the first time shows it in the black. We are still proud of our JOURNAL, of its place in medical journalism and leadership; we believe it is still, as it always has been, of service to the profession in carrying out the objects for which it was established by The Council and by our departed first editor, universal friend, and benefactor of medicine, Andrew P. Biddle.

TREASURER'S ANNUAL REPORT—1944

By Wm. H. Hyland, M.D.

Grand Rapids, Michigan

As Treasurer of the Michigan State Medical Society, I wish to submit the following report for the year 1944.

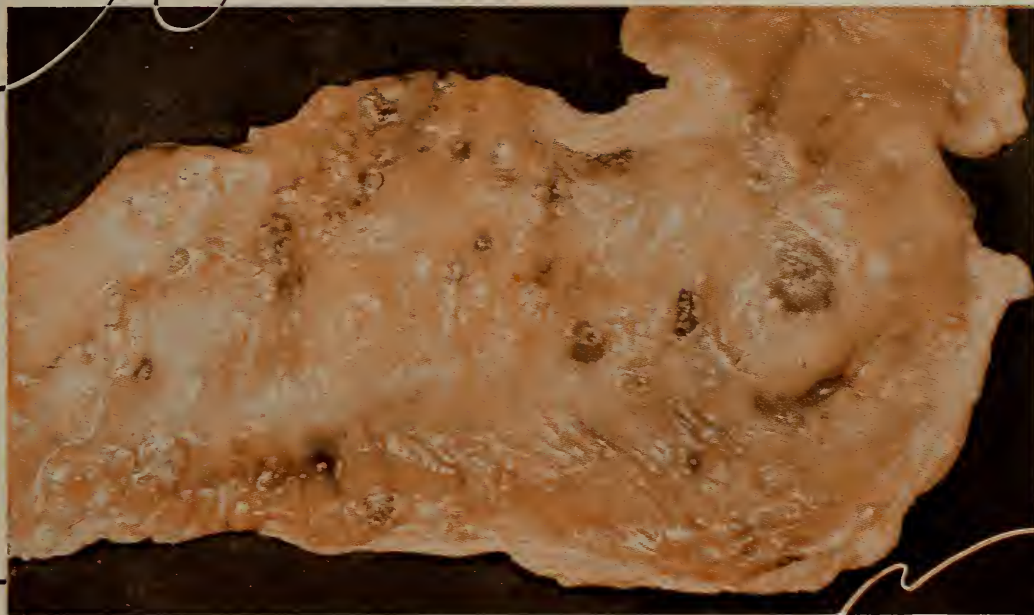
During the year a total of \$839.20 was received as income from interest coupons and dividends on bonds in the Treasurer's account, with interest accruing on United States Treasury Bonds.

(Continued on Page 502)

Presented to The Council, MSMS, in Annual Session, Detroit, January 26, 1945.



"SINCE many of the conditions obtaining among troops during war time are simultaneously factors which predispose to the endemic and epidemic spread of . . . amebic dysentery among military personnel and civilians . . . these diseases assume great significance . . . not only to the medical departments of the armed forces but to the civilian physician as well." —Lt. Com. W. L. Voegtlin, USNR: N.W. Med., 43:69 (1944)



Increased investigation into "tropical diseases" has disclosed the unsuspected prevalence of amebic dysentery in the United States.

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*Silverman, D. N.; Amer. J. Digest. Dis. & Nut., 4:281-282 (July) 1937.



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TREASURER'S ANNUAL REPORT

(Continued from Page 500)

The present value of the bonds and securities held by the Michigan State Medical Society, quoted market values as of December 30, 1944, is \$30,683.25.

By direction of the Executive Council of June, 1944, one Southern Pacific Railroad Bond, 4½%, maturity date, March 1, 1977, was purchased from the Trustee Fund in order to have sufficient funds on hand to pay for current expenses. Cost \$850.00.

By direction of the Executive Council in June, 1944, five thousand dollars were authorized and delivered to the Treasurer's account in United States Savings Bonds.

SECURITIES HELD BY THE MICHIGAN STATE MEDICAL SOCIETY ON DECEMBER 31, 1944

	Quoted Market Prices	during Period Ending Dec. 30, 1944
American Telephone and Telegraph Co.....	\$ 2,167.50	\$ 65.00
Government Dominion of Canada.....	1,025.00	30.80
Canadian Pacific Railway Company.....	1,975.00	80.00
Consolidated Oil Company.....	1,047.50	35.00
Consumers Power Company.....	1,077.50	32.50
Detroit Edison Company.....	2,155.00	70.00
Grand Rapids Affiliated Corporation.....	890.00	50.00
New York Central Railroad Company.....	1,775.00	80.00
Union Pacific Railroad Company.....	1,066.25	35.00
United Light and Power Company.....	1,042.50	55.00
Southern Pacific Railroad.....	987.50	22.50
United States Savings Bond—Series G....	4,940.00	62.50
United States Savings Bond—Series C....	6,600.00	150.00
United States Savings Bond—Series D....	1,105.00	26.00
United States Savings Bond—Series F....	1,917.50	32.50
United States Savings Bond—Series F....	532.00	7.70
United States Savings Bond—Series F....	380.00	5.50
	\$ 30,683.25	\$ 839.20

TRUSTEE'S ANNUAL REPORT—1944

By Wm. A. HYLAND, M.D., Grand Rapids, Michigan

As Trustee for the Michigan State Medical Society, I wish to submit the following report for the year 1944.

By direction of the Executive Council of June, 1944, one Southern Pacific Railroad Bond, 4½ per cent, maturity date 1977, was sold to the Treasurer's account in order to have sufficient funds on hand in the Trustee Account to pay for current expenses. Market price, \$850.00.

During the year a total of \$217.50 was received as income from interest coupons and dividends.

Total amount on hand in the Trustee Fund on January 1, 1944, \$522.92—Total deposits \$217.50. Out of this amount the bills of Douglas, Barbour, Densenberg and Purdy in the cases of

Facer vs. Lewis	150.00
Sova vs. Chapman	564.02
Caton vs. Tassie	152.00

were paid, making the total disbursements \$866.02.

Balance on hand January 1, 1945, in the Trustee Fund, \$724.40.

SECURITIES HELD IN THE TRUSTEE FUND OF THE MICHIGAN STATE MEDICAL SOCIETY WILLIAM A. HYLAND, TRUSTEE

Bond	Quoted Market Prices	Incomes Re- ceived During Period Ending Dec. 30, 1944
Grand Rapids Affiliated Corporation.....	\$ 890.00	\$ 50.00
New England Gas and Electric Association	1,800.00	100.00
Southern Pacific Railroad.....	987.50	45.00
Southern Pacific Railroad.....		22.50
	\$ 3,677.50	\$ 217.50

Presented to The Council, MSMS, in Annual Session, Detroit, January 26, 1945.

JOUR. MSMS

ROSTER of FACTS about YOUR MEDICAL SERVICE PLAN

- **Organized in 1939 by the Michigan State Medical Society.** The first subscriber was enrolled in March, 1940. Wholehearted public acceptance resulted in an enrolment of 93,000 subscribers by the end of 1940.
- **The Plan is available to all groups of ten or more people** and their eligible dependents (spouse and unmarried children under 19 years of age) as employees of a common employer, or as members of existing common interest organizations.
- **Individuals are not eligible for enrolment.** However, if a subscriber leaves the place of employment through which he enrolled, he may continue his coverage on an individual direct payment basis.
- **Operation of the Plan is under complete control of the medical profession.** The Articles of Incorporation provide that the Board of Directors must be composed of at least two-thirds doctors of medicine and must be elected by the members of the House of Delegates of the Michigan State Medical Society.
- **Benefits paid to doctors are determined by doctors themselves.** The Schedule of Benefits of Michigan Medical Service was compiled after consultation with, and as the result of recommendations by, committees representing the various special branches of medicine.

Reports of unusual services are reviewed and payment is authorized by Medical Advisory Boards composed exclusively of practicing physicians.

● As of April 1, 1945:	Number of Subscribers.....	777,104
	Services Rendered	270,000
	Payments to Doctors.....	\$10,514,359.37

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What's What

100% MEMBERSHIP FOR MAY, 1945

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 Clinton.....T. Y. Ho, M.D., Secretary
 Dickinson-Iron.....E. B. Anderson, M.D., Secretary*
 Grand Traverse-Leelanau-Benzie.....
 R. T. Lossman, M.D., Secretary
 Huron.....J. Bates Henderson, M.D., Secretary
 Jackson.....Horace Wray, Porter, M.D., Secretary
 Lapeer.....K. W. A. McLeod, M.D., Secretary
 Livingston.....Ray M. Duffy, M.D., Secretary
 Manistee.....C. L. Grant, M.D., Secretary
 Mason.....Chas. Paukstis, M.D., Secretary
 Menominee.....Wm. S. Jones, M.D., Secretary
 Midland.....Harold H. Gay, M.D., Secretary
 Muskegon.....Helen S. Barnard, M.D., Secretary
 Ottawa.....Gerritt J. Kemme, M.D., Secretary

*Deceased April 22, 1945

The American College of Chest Physicians has cancelled its Annual Meeting scheduled for Philadelphia in June, 1945.

* * *

Forty manufacturers of vitamins have launched the Vitamin Research Institute to assist advance of national nutrition standards.

* * *

The Wayne University Annual Alumni Clinic was held by the Alumni of the College of Medicine on Wednesday, May 16, in Detroit. Many members of the Michigan State Medical Society were present at this interesting one-day clinic, followed by dinner.

"It is not easy to get a bill passed by Congress. But the bureaucrats can toss off a directive while you wait. 'Directives' actually have the force of law."—Hatton W. Summers, member of Congress, and Chairman of the Judiciary Committee of the House.

* * *

Information covering the types of duties that may be expected by doctors of medicine in the Medical Corps of the U. S. Naval Reserve is available by writing the Office of Naval Officer Procurement, 1249 Washington Blvd., Detroit 26. D. F. Hoyt, Commander, MC, USNR, is the Senior Medical Officer in charge.

* * *


Total U. S. war expenditures from Pearl Harbor to March 1, 1945, \$245,000,000,000 of which 46 per cent were paid from taxes; balance, to increased public debt.

War expenditures to date are more than seven times the total of World War I, through June, 1919.—*Nation's Business*, March, 1945.

* * *

L. Fernald Foster, M.D., Secretary of the Michigan State Medical Society and J. C. Ketchum, Executive Vice President of Michigan Medical Service, outlined new benefits and developments in Michigan Medical Service, to the Kalamazoo Academy of Medicine and

(Continued on Page 506)



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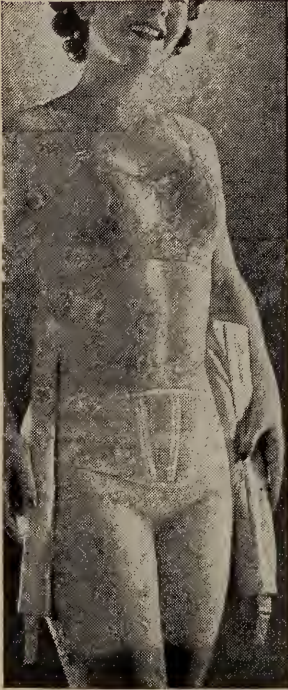
MAY, 1945

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505

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WHAT'S WHAT

(Continued from Page 504)

its Woman's Auxiliary, at Bronson Hospital on April 10. An interesting discussion followed the two talks and lantern slide demonstration.

* * *

O. Van Der Velde, M.D., of Holland, has addressed ten lay groups on "The Federalization of American Medicine." A list of the organizations inviting Dr. Van Der Velde include: Holland Professional Men's Club, Holland Rotary Club, Holland Kiwanis Club, Zeeland Rotary Club, Zeeland Lion's Club, Holland Teachers Men's Club, Hope College Scalpel Club, Hope Church School of Christian Living, Episcopal Church Men's Club, and the Grand Haven Kiwanis Club.

* * *

Insurance Program Legislation.—So far in 1945, laws authorizing organization and operation of nonprofit medical service planned corporations have been enacted in Tennessee, Iowa, and North Dakota. Similar bills are in process of enactment in Kansas, Minnesota, and South Dakota. In addition, a law permitting a nonprofit hospital service corporation to operate a supplementary medical service plan in conjunction with a hospital service plan has been enacted in West Virginia.

* * *

Percy Jones General and Convalescent Hospital of Battle Creek presented J. W. Conn, M.D., of Ann Arbor at its staff conference of April 2. Dr. Conn spoke on "Hypoglycemia." F. Bruce Fralick, M.D., Ann Arbor, spoke on "Malignant Exophthalmos" on April 9; I. G. Uhrie, M.D., Battle Creek, spoke April 16 on "Modern Diagnosis and Treatment of Periodontoclasia."

Arthur C. Curtis, M.D., Ann Arbor, addressed the weekly staff conference of April 23 on "Recent Advances in the Treatment of Syphilis"; Max M. Peet, M.D., Ann Arbor, was guest speaker on April 30 on "Surgical Treatment of Vascular Hypertension."

* * *

"Despite all the upheavals and dislocations of the war-time civilian population, public health is improving in this country according to a survey made public March 1 by the Office of War Information.

"The estimated 1944 national civilian rate of death from all causes fell from 10.6 per one thousand population against 10.9 in 1943 and 10.7 in 1940 before we entered the war."—*Chicago Daily News*, March 1, 1945.

And yet the urge is on for adoption of political medicine which would set back medicine a generation! Let us not lose the golden eggs of medical advance by killing the goose.

* * *

Right of Employed Doctors.—The Circuit Court of Appeals for the third Federal Circuit has rendered a decision on the first case arising under Section 8 of the Selective Service Act involving the right of a physician to be reinstated to a position he held prior to entering the armed forces. The judgment establishes a

(Continued on Page 508)

JOUR. MSMS

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and Aged)**

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ARE NOT ENOUGH!**

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WHAT'S WHAT

(Continued from Page 506)

precedent that may be of great importance to doctors of medicine who seek reappointment to hospital positions after discharge from the Army and Navy. Under the court's ruling such physicians can clearly compel hospitals to reappoint them if in their former position they were "in the employ of" a hospital corporation on a salary or percentage basis. *Kay vs. General Cable Corp.*, 144 F. (2d) 653.

* * *

Wm. J. Seymour Hospital, Eloise, Michigan, held a Postgraduate Cancer Clinic on Wednesday, May 23, beginning at 2:30 p.m., EWT.

T. K. Gruber, M.D., Superintendent of Eloise Hospital and Infirmary, introduced the speakers: Wm. A. Hyland, M.D., Grand Rapids; David Littlejohn, M.D., Dearborn, and Frank L. Rector, M.D., Lansing, who spoke on "Cancer Control."

"Practical Considerations in Diagnosis and Management of Cancer" presented by members of the Seymour Hospital staff: S. E. Gould, M.D., C. A. Doty, M.D., A. Z. Howard, M.D., C. J. Smyth, M.D., M. R. McQuiggan, M.D., W. L. Sherman, M.D., N. K. H'Amada, M.D., J. M. Grace, M.D., and Carl Moyer, M.D.

* * *

President A. S. Brunk, M.D., Secretary L. Fernald Foster, M.D., and J. C. Ketchum, Executive Vice President, Michigan Medical Service, were invited by the Medical Society of the State of Pennsylvania to appear before the Pennsylvania State Senate Public Health Committee on April 17. Under discussion was a bill offered by a Blue Cross Plan Director in Pennsylvania which would give control of medical service plans in that state to Blue Cross or group hospitalization organizations.

The Michigan representatives certified to the smooth performance and cordial relations existing between Michigan Medical Service and Michigan Hospital Service in the administration of the health service program in Michigan, to prove that an efficient organization could be developed with the complete separation of medical care and hospital service.

* * *

The Genesee County Medical Society Bulletin of April 10 contained a thoughtful editorial on voluntary vs. compulsory health insurance plans. A paragraph from the editorial follows: "On the one hand, then, we have medical men trying to work out by the method of trial and error a better plan for administering medical service to the people, and, on the other, a group of lefthanded politicians who are trying to legislate good health. There is recorded evidence that these senatorial committees intend to proceed without the co-operation of the medical profession since they claim that such co-operation had earnestly been sought but that the profession simply did not respond. Again, on

(Continued on Page 510)

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WHAT'S WHAT

(Continued from Page 508)

one hand, we have medical men and earnest laymen grubbing away patiently to work out sound plans for prepaid medical service, and on the other politically minded office holders moon gazing at the harvest moon of a huge tax fund."

* * *

The MSMS radio programs over WJR, Fridays, 7:15 to 7:30 p.m., EWT., have featured song and story and a brief talk by a representative of the Michigan State Medical Society. Councilors and officers of the State Society have been drafted to present the weekly medical statement as follows:

Feb. 16—C. L. Candler, M.D., Detroit—Introductory Statement
Feb. 23—L. Fernald Foster, M.D., May City—"Purposes of Michigan State Medical Society"
March 2—Wm. A. Hyland, M.D., Grand Rapids—"Michigan Medical Service"
March 9—O. D. Stryker, M.D., Fremont—"Medical Men in Service"
March 16—Wilfrid Haughey, M.D., Battle Creek—"Psychiatry After the War"
March 23—E. F. Sladek, M.D., Traverse City—"Voluntary Programs of Medical Care"
March 30—R. S. Morrish, M.D., Flint—"Health Education of the Public"
April 6—P. L. Ledwidge, M.D., Detroit—"Protection Against Major Hazards of Illness"
April 20—C. E. Umphrey, M.D., Detroit—"Postgraduate Medical Education"
April 27—L. J. Hirschman, M.D., Detroit—"New Benefits Under Michigan's Blue Cross Plans"
May 4—A. S. Brunk, M.D., Detroit—"Progressive Michigan Medicine"
May 11—O. O. Beck, M.D., Birmingham—"Our Medical Veterans' Readjustment Program"
May 18—E. R. Witwer, M.D., Detroit—"Greater Safety and Health for All Workers in Industry"
May 25—W. E. Barstow, M.D., St. Louis—"A Friend in Need"
June 1—A. B. Smith, M.D., Grand Rapids—"Blue Cross Plans and Preventive Medicine"
June 8—D. W. Myers, M.D., Ann Arbor—"Benefits of Voluntary Programs of Health Care"
June 15—T. E. DeGurse, M.D., Marine City—"History Repeats"
June 22—F. H. Drummond, M.D., Kawkawlin—"Evils of Compulsory Systems"
June 29—R. J. Hubbell, M.D., Kalamazoo—"America Needs Medical Students NOW"

* * *

A Cancer Teaching Day was held in Traverse City on March 9. Participants were the Grand Traverse-Leelanau-Benzie Medical Society, and the Division of Cancer Control, Michigan Department of Health. Henry K. Ransom, M.D., H. Marvin Pollard, M.D., and R. L. Haas, M.D., of Ann Arbor were the visiting consultants and provided the day's program.

The morning program consisted of consultations with local physicians on patients with conditions known or suspected of being cancerous, and operative clinics in surgery and gynecology.

The regular weekly meeting of the Tumor Clinic was held at the Munson Hospital during the afternoon at which thirteen patients were examined and their condition discussed by the visiting consultants. The types of cancer presented were of the lip, maxillary sinus, thyroid, metastatic melanoma, cervix, uterine corpus, Wilms tumor, Hodgkins Disease and myelogenous leukemia. Some of these cases had returned for observation only, while others were new cases seen for the first time.

At the dinner meeting, Dr. Pollard discussed the diag-

(Continued on Page 512)

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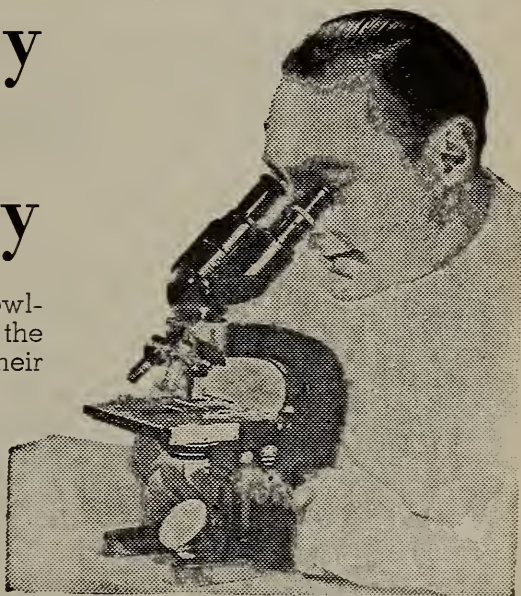
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WHAT'S WHAT

(Continued from Page 510)

nosis of cancer of the stomach, especially the value of the gastroscope in this procedure. Dr. Ransom spoke on treatment of cancer of the colon. Dr. Haas reviewed cancer of the cervix, corpus, and ovary, discussing their differential diagnosis, treatment and prognosis.

Thirty-five physicians from northwest Michigan attended this day's program—the first of its kind to be held in Michigan. One physician traveled a distance of 125 miles to be present. The success of this meeting has caused the local medical society to announce that a similar meeting will be held next year.

The week's cancer education program for both lay and professional groups marks the beginning of a series of such programs to be offered the counties through their local medical societies, the State Medical Society and the Michigan Department of Health.

* * *

Causes of Death

As usual heart disease led all other causes of death in Michigan, with cancer second. During the first nine months there were 12,590 deaths due to heart disease as against 12,932 for the same period last year. Cancer was in the second place for the nine-month period with 5,176 deaths, followed by apoplexy, 3,616; accidents, 2,467; inflammation of kidney, 2,062; pneumonia, 1,827; tuberculosis, 1,373; diabetes, 1,149; premature births, 1,063, and hardening of the arteries, 757.

* * *

Radiologists Not Subject to Sales Tax

A ruling made by the deputy comptroller of the Department of Finance in New York City attempted to classify radiologists as subject to the sales tax by assuming that they were engaged in the sale of merchandise when taking x-ray films of patients. Prompt action by the American College of Radiology in filing a brief with the court caused the comptroller to withdraw his ruling with respect to licensed physicians who practice radiology. The brief pointed out that radiologists *did* make diagnoses and it explained that when these medical specialists made examinations of patients with the aid of radiographs they did not "furnish the same to such persons." The brief also called attention to the fact that the prevailing weight of judicial opinion held that radiographs were the legal property of the radiologist and that the patient had no right of possession to them.

* * *

American Board of Obstetrics and Gynecology

The general oral and pathology examinations (Part II) for all candidates will be conducted at Hotel Shelburne, Atlantic City, New Jersey, by the entire Board from Wednesday, June 13, through Tuesday, June 19, 1945. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the hotel.

(Continued on Page 514)

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WHAT'S WHAT

(Continued from Page 512)

Candidates for *re-examination* in Part II must make written application to the Secretary's Office not later than April 15, 1945.

The Office of the Surgeon General (U. S. Army) has issued instructions that men in Service, eligible for Board examinations, be encouraged to apply and that they may request orders to Detached Duty for the purpose of taking these examinations whenever possible.

Candidates in Military or Naval Service are requested to keep the Secretary's Office informed of any change in address.

Deferment without time penalty under a waiver of our published regulations applying to civilian candidates, will be granted if a candidate in Service finds it impossible to proceed with the examinations of the Board.

* * *

Gordon Scott Assumes Post At Wayne Medical School

Dr. Gordon H. Scott, formerly head of the department of anatomy at the University of Southern California School of Medicine, has assumed his duties as professor and head of the department of anatomy at the Wayne University College of Medicine.

He has been particularly active in applying new physical equipment to medical research and has contributed notably to microanalytic techniques, especially in the field of microincineration.

He is now studying the effects of phantom limb pain and joint pain, a problem of great importance in the management of war casualties. Another current study, inspired by the needs of aviation medicine, deals with the capillary circulation of the lungs and brain.

Dr. Scott is a graduate of Southwestern College, Kansas, and later studied at Johns Hopkins and the University of Minnesota, taking his A.M. at Minnesota in 1925 and a Ph.D. the following year. He worked a year with Dr. E. V. Cowdry of the Rockefeller Institute of Medical Research and has taught in the schools of medicine of Loyola University, Washington University, and the University of Southern California.

He is a member of the National Research Council Committee on Biological Application of the Electron Microscope, the American Association of Anatomists, the American Society of Zoologists, and the American Association of Pathologists and Bacteriologists.

* * *

Dean, Wayne University School of Occupational Health

Lieutenant Colonel Raymond G. Hussey, MC, Director of the Army Industrial Hygiene Laboratory, Baltimore, Md., has retired from active duty to accept appointment as Dean of the School of Occupational Health which he is now organizing at Wayne University, Detroit, Michigan.

Colonel Hussey is one of the foremost authorities in the field of occupational health. His development of

(Continued on Page 516)



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COMMUNICATION

WHAT'S WHAT

(Continued from Page 514)

the Army Industrial Hygiene Laboratory under the Preventive Medicine Service, Office of The Surgeon General, represents a new departure in this field of preventive medicine in the United States Army. At Wayne University he will organize the first formal program of educational health and medicine.

Colonel Hussey received his M.D. degree from the University of Maryland School of Medicine and College of Physicians and Surgeons in 1911. He entered the Army as a first lieutenant in 1917. During World War I he was Commanding Officer of the Central Medical Laboratory and had reached the rank of lieutenant colonel when he returned to civilian life in 1919. Subsequently he became professor of pathology at Yale University School of Medicine and then at the University of Maryland. He was chairman of the Maryland State Board for Occupational Diseases and is a member of the Council on Industrial Health of the American Medical Association.

Communication

March 15, 1945

To the Editor:

The reason for this letter is the apparent relationship of the presence of swallows to the appearance of poliomyelitis. Swallows, in many states, group for migratory flight in August and are gone by late September. The flareup and recession of poliomyelitis corresponds to the grouping and disappearance of swallows.

Poliomyelitis, in cold states, disappears with heavy frost and does not reappear until after the swallows return. The reappearance of poliomyelitis is not strictly in conformity with the time of their return; however, the thought is that the birds might carry some infective agent themselves or in the form of a bug or mite attached to them.

The worldwide distribution of poliomyelitis, the fact that it seems to be carried rather than spread, its prevalence in temperate zones are other factors. Swallows are world travelers, going from the Gulf of Mexico to Japan, China, et cetera, and returning each year.

The grouping of swallows at the source of the water supply or between it and the filtration plant should be investigated. This could be a possible source of infection, especially when we consider the virus as being highly filtrable and highly resistant to known bacteriacidal agents.

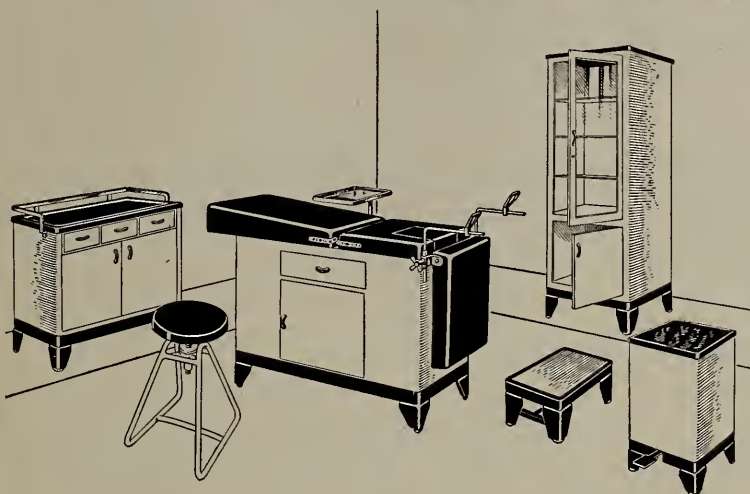
Thank you for your co-operation. I shall be interested to hear from you regarding any apparent relationship of swallows to poliomyelitis.

Yours very truly,

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Pamphlets Received

NATIONAL RESEARCH COUNCIL, DIVISION OF MEDICAL SCIENCES: KEYS TO THE MOSQUITOES OF THE AUSTRALIAN REGION. Including a Synopsis of Their Distribution and Breeding Habits. By Kenneth L. Knight, Lieutenant, H-V(S), U.S.N.R., Richard M. Bohart, Lieutenant (jg), H-V(S), U.S.N.R., and George E. Bohart, Lieutenant, H-V(S), U.S.N.R. United States Naval Research Unit No. 2. Issued by the Office of Medical Information. (Under grant of Johnson & Johnson Research Foundation). Washington, July, 1944.

SPONTANEOUS PNEUMOTHORAX. By James J. Waring, M.D. Issued by the Office of Medical Information (Under grant of the Johnson & Johnson Research Foundation). Washington, July, 1944.

THE BLOOD PLASMA PROGRAM. By James A. Phalen, M.D., Colonel, U. S. Army. Issued by the Office of Medical Information (Under grant of the Johnson & Johnson Research Foundation). Washington, July 25, 1944.

ANTIMALARIAL DRUGS, GENERAL OUTLINE. By Owsei Temkin, M.D., and Elizabeth M. Ramsey, M.D. Issued by the Office of Medical Information (Under grants of the Carnegie Corporation and the Johnson & Johnson Research Foundation). Washington, March, 1944.

APPROVED LABORATORY TECHNIC. Clinical Pathological, Bacteriological, Mycological, Virological, Parasitological, Serological, Biochemical and Histological. By John A. Kolmer, M.S., Dr.P.H., Sc.D., LL.D., L.H.D., F.A.C.P., Professor of Medicine in the School of Medicine and the School of Dentistry, Temple University; Formerly Professor of Pa-

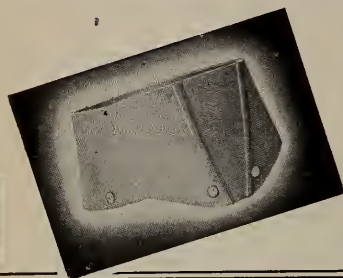
thology and Bacteriology, Graduate School of Medicine, University of Pennsylvania; and Fred Boerner, V.M.D., Associate Professor of Clinical Bacteriology, Graduate School of Medicine and Assistant Professor of Bacteriology, School of Medicine, University of Pennsylvania. Fourth Edition. New York and London: D. Appleton-Century Company, 1945. Price \$10.00.

The fourth edition of this long-time standard text is completely up to the minute, containing the various methods of testing the susceptibility of bacteria to penicillin, the blood grouping tests, including the new Ph. The Kolmer Complement fixation tests for syphilis are given with many other substitutes for the Wassermann, such as the Kahn, and others. The book is complete, containing well-written descriptive articles on all the tests and methods of laboratory procedure.

INTERNAL MEDICINE, Its Theory and Practice. In Contributions by American Authors. Edited by John H. Musser, B.S., M.D., F.A.C.P., Professor of Medicine in the Tulane University of Louisiana School of Medicine; Senior Visiting Physician to the Charity Hospital, New Orleans, Louisiana. Fourth Edition, Thoroughly Revised. Illustrated. Philadelphia: Lea & Febiger, 1945. Price \$10.00.

Musser's Internal Medicine has become a standard work, and this edition is much enlarged compared to the former. Much of war medicine has been added, and the newer chemotherapy and penicillin are discussed in connection with Coccal diseases. Vitamins are described and discussed under the heading of Diseases of Nutrition. Chapters are contributed by many authors, heads of departments of universities, or special departments of medical schools. Cyrus C. Sturgus, M.D., of

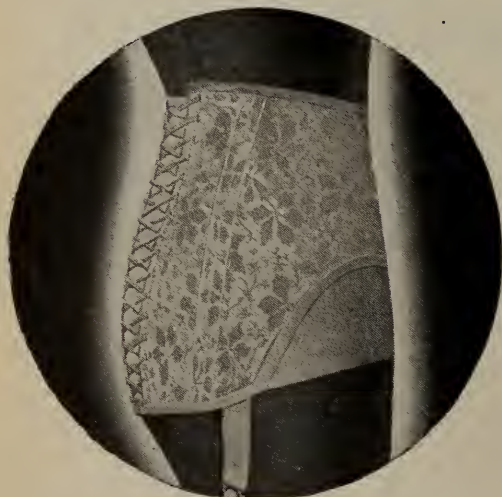
(Continued on Page 520)



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(Continued from Page 518)

the University of Michigan has a Chapter on Diseases of the Blood. This volume of 1518 pages is complete and sufficiently in detail to be a valuable reference.

PROTEINS AND AMINO ACIDS, Physiology, Pathology, and Therapeutics. Yonkers, New York: The Arlington Chemical Company. Free.

An attractively arranged and well-printed book on the general subject of the title. No authors are mentioned, but voluminous references are given to authors in J.A.M.A., Ann. Int. Med., Arch. Int. Med., Am. J. Path., Ann. Surg., et cetera.

THE ABORTION PROBLEM. Proceedings of the Conference Held Under the Auspices of the National Committee on Maternal Health, Inc., at the New York Academy of Medicine June 19 and 20, 1942. Howard C. Taylor, Jr., M.D., Conference Chairman. Published for the National Committee on Maternal Health, Inc., Baltimore: The Williams and Wilkins Company, 1944.

This is a long and involved discussion of the abortion problem. Three chapters are devoted to the magnitude of the problem, and the inadequacy of the figures. Spontaneous abortion and its prevention, four chapters. Social, Moral and Economic causes, three chapters. The control of the abortion problem, six chapters. Papers by Dr. T. Baynard Carter of Duke University and Dr. John Cooper, Department of Sociology, Catholic University of America, are not published by request of the authors. Many tables and figures are given and the discussion seems fair and scientific.

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Medical Industrial Conference

The Third Annual Postgraduate Industrial Medical and Surgical Conference, sponsored by the Committee on Industrial Health of the Michigan State Medical Society in co-operation with the Department of Postgraduate Medical Education of the University of Michigan, was held in Detroit on April 6 and attended by 155 persons.

Praise for the quality of the program and the smoothness of the physical arrangements in the Rackham Educational Memorial was elicited by the registrants. A. S. Brunk, M.D., President of the Michigan State Medical Society, presided at the morning meeting at which "Present-day Wartime Problems" were discussed by W. B. Harm, M.D., Detroit; E. A. Irvin, M.D., Detroit; Theodore P. Ryan, LL.B., Lansing, and Dudley A. Irwin, M.D., Pittsburgh.

P. L. Ledwidge, M.D., Detroit, was presiding officer at the afternoon meeting which featured a symposium on "Postwar Problems of Industrial Health and Medicine." The leader of the symposium was Raymond Hussey, M.D., Dean of the new School of Occupational Health of Wayne University, Detroit. Members of the panel were O. L. Beardsley, M.D., of Detroit; F. E. Poole, M.D., Burbank, California; H. Graham Ross, M.D., Montreal, Canada, and Major Roy P. Warren, Sn.C.; AUS, Baltimore, Maryland.

The general chairmen of the day were Kenneth E. Markuson, M.D., Lansing, Chairman of the MSMS Industrial Health Committee, and C. D. Selby, M.D., Detroit.

Those attending the 1945 Industrial Conference were:

F. T. Andrews, M.D., Bay City; A. L. Arnold, Jr., M.D., Owosso; Ira Avrin, M.D., Detroit; Michael A. Baeff, M.D., Detroit; Clarence Baker, M.D., Detroit; O. L. Beardsley, Detroit; William J. Becker, Detroit; Dorothy Bell, Ipsilanti; Mary E. Bouman, Grand Rapids; Franklin T. Bower, M.D., Detroit; D. S. Brachman, M.D., Detroit; Mrs. June Breen, R.N., Buchanan; Henry S. Brown, M.D., Detroit; A. S. Brunk, M.D., Detroit; John D. Buck, M.D., Detroit; Max Burnell, M.D., Flint; G. W. Byington, M.D., Detroit; L. B. Case, Detroit; E. W. Caster, M.D., Flint; Clark A. Carmody, Detroit; R. G. Colyer, M.D., Detroit; R. A. Cook, Flint; Stewart T. Cooper, St. Joseph; R. P. Coughlin, M.D., Detroit; H. A. Cousins, Detroit; F. S.

Curry, M.D., Detroit; W. A. Dawson, M.D., Detroit, and Carleton Dean, M.D., Lansing.

P. H. Darpin, M.D., Detroit; Pearl L. Davis, R.N., Detroit; Senter P. Deacey, Flint; Edwin DeJongh, M.D., Detroit; Marion Dixon, Detroit; John D. Donovan, M.D., Detroit; Gertrude Dwyer, R.N., Detroit; Harry E. Edwards, Ph.D., Buchanan; Clarence H. Eisman, M.D., Detroit; L. Fernald Foster, M.D., Bay City; William G. Frederick, Detroit; Chas. E. Fuller, Flint; Alfred C. Funke, Detroit; Harold H. Gay, M.D., Midland; J. H. Ganschow, M.D., Detroit; W. C. Gibson, M.D., Milford; Neysa Gilroy, R.N., Wayne; W. L. Green, M.D., Kalamazoo; A. S. Guimaraes, M.D., Dearborn; T. S. Hancock, Milford; W. B. Harm, M.D., Detroit; Janice Hastings, R.N., Kalamazoo; Wilfrid Haughey, M.D., Battle Creek; C. K. Halsey, M.D., Detroit, and Bolo Douglas Hilty, Pontiac.

L. E. Himler, M.D., Ann Arbor; Marjorie W. Hobbs, Ferndale; A. J. Hollander, M.D., Detroit; Raymond Hussey, M.D., Detroit; E. A. Irvin, M.D., Detroit; Dudley A. Irwin, M.D., Pittsburgh; Marion W. Jocz, M.D., Detroit; M. D. Johnson, M.D., Detroit; N. J. Kapetansky, M.D., Detroit; Fannie Keen, Detroit; Mrs. Jessie M. Kelley, R.N., Grand Rapids; William Y. Kennedy, M.D., Detroit; George Kingsbury, Wayne; David Kliger, M.D., Detroit; Lewis L. Kline, M.D., Detroit; T. Kolvoord, M.D., Battle Creek; William T. Kregs, M.D., Detroit; Henry J. Kreulen, M.D., Grand Rapids; L. W. Lang, M.D., Detroit; E. J. Lauretti, M.D., Muskegon; V. S. Laurin, M.D., Muskegon, and R. C. Leacock, M.D., Detroit.

P. L. Ledwidge, M.D., Detroit; A. L. Lent, Detroit; B. H. Van Leuven, M.D., Lansing; Gerald A. Lewis, Detroit; W. E. Libby, East Lansing; Lt. Benjamin Linsky, Detroit; Evelyn Louisda, R.N., Jackson; Wm. L. Lovett, Ferndale; Earl F. Lutz, M.D., Detroit; F. E. Macaulay, Pontiac; Mabelle Markee, Lansing; K. E. Markuson, M.D., East Lansing; W. H. Marsh, M.D., Homer; Wm. H. Marshall, Pontiac; Lyndle R. Martin, M.D., Detroit; Arnold A. McCready, Saginaw; Fred T. McDermott, Pontiac; E. G. McPherson, M.D., Dearborn; Earl Merritt, M.D., Detroit; Lorin G. Miller, East Lansing; Hellen Monroe, Grand Rapids; Robert Mitchell, Monroe; Thomas F. Mooney, Detroit; G. E. Morrison, Battle Creek; Felipe Murd, M.D., Dearborn; Victor C. Myers, M.D., Lansing; Myrtle Miller, Detroit; C. Charlotte Nelson, R.N., Detroit; Jean O'Leary, Jackson; F. A. Patty, Detroit; O. B. Paxton, Wyandotte; George F. Pierrot, Detroit; F. E. Poole, M.D., Burbank, Calif.; Katharine Post, Lansing; R. H. Potter, Detroit; Kenneth W. Power, Detroit; Otto J. Preston, M.D., Flint; and Martha Purcell, Detroit.

Morris Raskin, M.D., Detroit; P. B. Rastello, M.D., Detroit; R. W. Rawson, Detroit; J. W. Riegel, Ann

(Continued on Page 554)



ERYSIPELOID

(Rosenbach's Disease)

Not to be confused with streptococcic erysipelas, this extremely painful, and sometimes even fatal infection is caused by *Erysipelothrix rhusiopathiae*. It is observed rather frequently among those brought into contact with animals and fish.

Veterinarians, slaughterhouse-workers, butchers, farmers, bone-button makers, fish-handlers and cooks are most likely to contract the condition, which usually starts as an erythema at the site of primary infection, notably the fingers.

Now—WELL-TOLERATED TREATMENT WITH *Concentrated* ANTI-ERYSIPELOID SERUM

(PITMAN-MOORE)

HOW SUPPLIED

Pitman-Moore Concentrated Anti-Erysipeloid Serum is available in 10 cc. vials. Two to five cc. is usually adequate for the initial dose. In some instances repeated or increased dosage will not be necessary.

Since the disease in animals responds to sero-therapy, the unrefined anti-swine erysipelas serum was employed in human cases, with much success. However, this unconcentrated serum, in effective dosage, leads rather frequently to anaphylaxis and serum reactions.



REDUCED REACTIONS—To minimize this objection, Pitman-Moore Laboratories have developed a *concentrated* and *refined* anti-serum for human use, in which the volume is reduced as much as 80%.

Complete information to physicians on request.

PITMAN-MOORE COMPANY

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

Division of  *Allied Laboratories, Inc., • Indianapolis 6, Indiana*

Seventeen State Society Presidents Meet in Michigan

A conference of seventeen presidents of active state medical societies, sponsored by the Michigan State Medical Society and its Special Committee on Radio, was held in Detroit, Friday and Saturday, April 27-28, 1945.

The two-day meeting featured a tour of Michigan Medical Service, the voluntary group medical care plan sponsored by the Michigan State Medical Society; a special audition of the MSMS radio program over WJR, Friday, at 7:15 p.m., a presentation of the MSMS Drafting Panel's "Outline" for medical legislation, and a meeting with the Executive Committee of The Council of the Michigan State Medical Society for a discussion of mutual problems and plans.

The highlight of the two-day meeting was the Conference on "Radio Advertising by the Medical Profession" arranged Friday evening after the MSMS radio hour.

Discussion leaders on various topics and programs sponsored by the Michigan State Medical Society were President A. S. Brunk, M.D., Detroit; Speaker P. L. Ledwidge, M.D., Detroit; Secretary L. Fernald Foster, M.D., Bay City; Radio Chairman C. L. Candler, M.D., Detroit. Technical details of the radio program were presented by Charles Burke of WPR and C. H.



C. F. KETTERING DISCUSSES PUBLIC RELATIONS WITH MSMS OFFICIALS
Detroit, April 27, 1945

Left to right: L. Fernald Foster, M.D., Bay City, MSMS Secretary; C. F. Kettering, Detroit, Vice President in Charge of Research, General Motors Corporation; A. S. Brunk, M.D., Detroit, MSMS President; and C. L. Candler, M.D., Detroit, Chairman, MSMS Special Committee on Radio.

Chapman of the Chapman Advertising Agency, Detroit.

Guest speaker at the dinner of April 27 was C. F. Kettering, Vice President and Director of Research, General Motors Corporation, Detroit.

A tour of Willow Run, the mammoth Ford Bomber plant, was enjoyed by the visitors on Saturday morning.

States represented at this informal gathering were Connecticut, Delaware, District of Columbia, Kentucky, Illinois, Indiana, Iowa, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey,

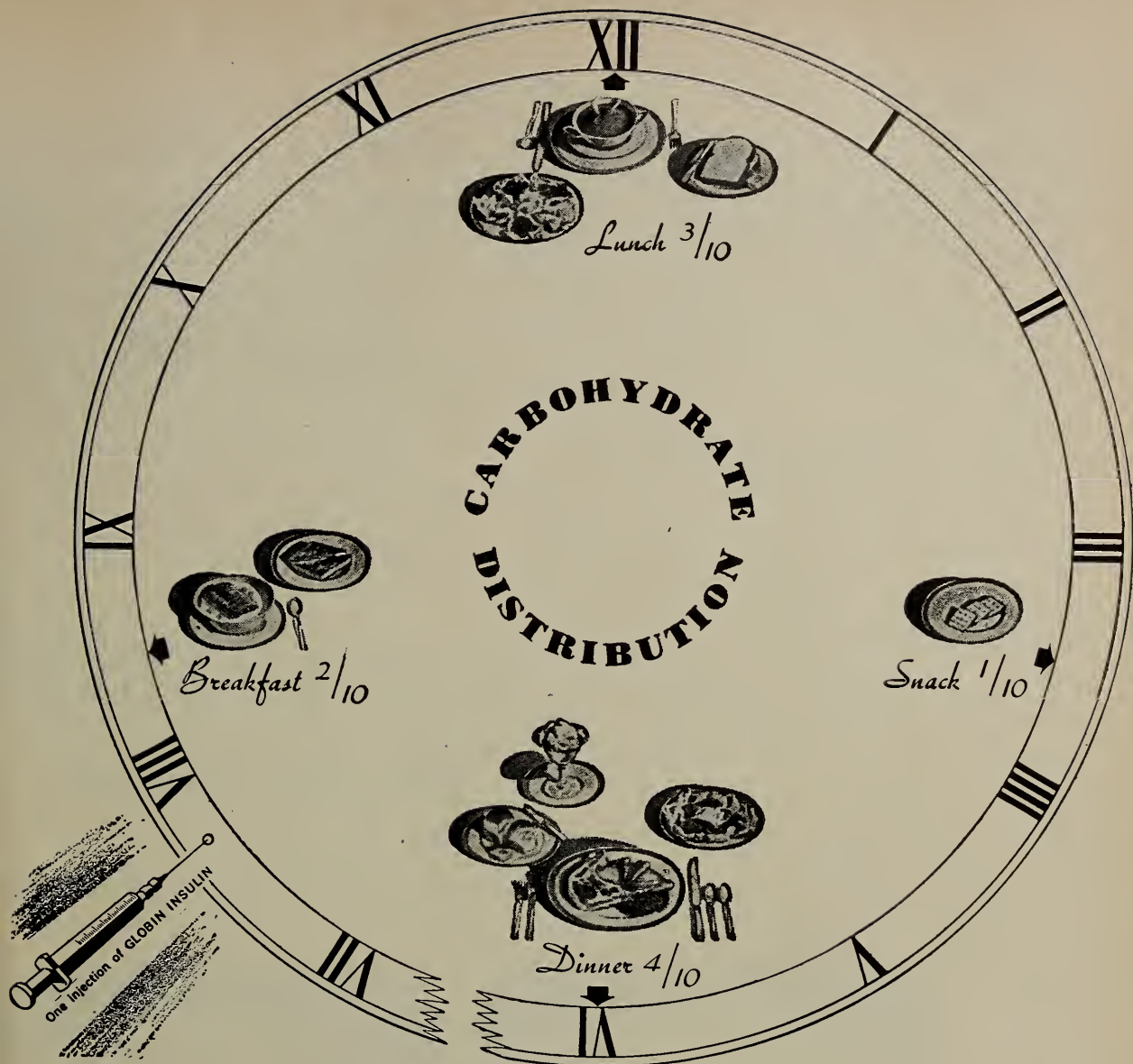
(Continued on Page 544)



STATE MEDICAL SOCIETY PRESIDENTS AND OTHERS AT MSMS PUBLIC RELATIONS CONFERENCE
Detroit, April 27-28, 1945

Front, left to right (seated): L. Howard Schriver, M.D., Ohio; Joseph H. Howard, M.D., Connecticut; N. K. Forster, M.D., Indiana; O. O. Miller, M.D., Kentucky; A. S. Brunk, M.D., Michigan; Charles Fidler, M.D., Wisconsin; Elihu Wing, M.D., Rhode Island; J. F. Londrigan, M.D., New Jersey, and E. J. McCormick, M.D., Ohio.

Back, left to right: J. B. Lukins, M.D., Kentucky; William Bates, M.D., Pennsylvania; E. S. Bagnell, M.D., Massachusetts; L. F. Donohoe, M.D., New Jersey; E. L. Tuohy, M.D., Minnesota; Wm. M. Ballinger, M.D., District of Columbia; F. L. Rogers, M.D., Nebraska; R. D. Bernard, M.D., Iowa; E. P. Coleman, M.D., Illinois; I. L. Chipman, M.D., Delaware; and H. H. Baucus, M.D., New York.



DIABETES CONTROL *in tenths*

The physician planning a diabetic's diet with 'Wellcome' Globin Insulin will find it convenient to divide his patient's carbohydrate intake into tenths. Two-tenths for breakfast, three-tenths for lunch, one-tenth for a mid-afternoon snack, and four-tenths for supper will be found satisfactory for most patients.

Such a regime plus one injection of Globin Insulin daily will control most mild, moderate, and many severe cases of diabetes. Action is rapid in onset, sustained during daytime activity, and diminished at night—thus minimizing the likelihood of nocturnal reactions.



Literature on Request

'Wellcome' Globin Insulin with Zinc is a clear solution and, in its relative freedom from allergenic properties, is comparable to regular insulin. Council accepted. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc.

'Wellcome' Trademark Registered



BURROUGHS WELLCOME & CO. (U. S. A.) INC., 9 & 11 East 41st Street, New York 17, N. Y.





Research

on ERTRON
in Arthritis



For over ten years, Ertron in the treatment of arthritis has been studied intensively in leading universities, hospitals, clinics and private practice.

Reports and follow-up surveys have appeared regularly in leading medical journals. This work is still going on, as new methods of attack are evolved.

These studies confirm both the effectiveness of Ertron in arthritis and the non-toxicity of Ertron in therapeutic dosage.

The clinical work has been done on Ertron—the bibliography specifies

Ertron—the results apply to Ertron alone—no other product contains electrically activated vaporized ergosterol (Whittier Process).

Complete bibliography and mode of administration will be sent to interested physicians.

ERTRONIZE THE ARTHRITIC

Ertronize Means: Employ Ertron in an adequate daily dosage over a sufficiently long period to produce optimal results. Gradually increase the dosage to that recommended or to the toleration level. Maintain this dosage until maximum improvement occurs.

Capsules—bottles of 50, 100 and 500.

Parenteral—packages of six 1 cc. ampules.

ETHICALLY PROMOTED

NUTRITION RESEARCH LABORATORIES • CHICAGO

Ertron is the registered trade-mark of Nutrition Research Laboratories.

Views of the right hand of a male, aged 40 years; illustrating a typical atrophic or rheumatoid arthritis; duration of disease, 12 years; occupation, filling station attendant, bookkeeper.

This hand illustrates an advanced stage of the disease with marked muscular atrophy and absence of subcutaneous fat. The gross appearance is exaggerated by the chronic subnutritional status of the patient. The atrophic changes of the musculature with involvement of supporting tendons have resulted in marked deformities and a functionless claw hand. The metacarpals as well as the fingers particularly show subluxations with typical ulnar deviations. The nails are markedly thickened and horn-like and falsely suggest psoriatic changes. General symmetrical involvement: nearly all joints in body with extensive ankylosis of shoulders, jaws, knees, ankles, wrists and hands. Patient is a complete invalid and takes only soft, ground food due to inability to masticate. X-ray shows areas of atrophic destruction and marked decalcification of the osseous structure, subluxations and overriding of the bones.



You and Your Business

MICHIGAN MEDICAL FOUNDATION

"The Michigan Foundation for Medical and Health Education" was recently incorporated under the sponsorship of the Michigan State Medical Society.

The purposes of the Michigan Foundation are: "To acquire, provide, use, develop, endow, and finance methods, means and facilities for postgraduate education in medicine, for lay health education, and for research, fellowships, and scholarships, all in such manner as the Trustees shall determine. This corporation is organized and shall be operated exclusively for benevolent, scientific and educational purposes and its property shall be used by it solely for the purposes for which it is incorporated."

The Michigan Foundation for Medical and Health Education is organized on a non-stock basis and will be financed by contributions and bequests. The membership is composed of the members of The Council of the Michigan State Medical Society, together with the incorporators, the elected Board of Trustees of the corporation, and others elected to membership by a two-thirds vote of the members.

The contributions made to the Michigan State Medical Society Foundation for Postgraduate Medical Education, created in 1942 by the State Medical Society, will be transferred to the new Foundation. The Michigan Foundation for Medical and Health Education is the result of over a year's study by the Postgraduate Foundation Committee composed of James D. Bruce, M.D., Ann Arbor, Chairman; E. I. Carr, M.D., Lansing; B. R. Corbus, M.D., Grand Rapids; J. M. Robb, M.D., Detroit; and R. H. Stevens, M.D., Detroit. The late Fred B. Miner, M.D., of Flint was an active member of this Committee until his recent death.

Interesting plans to attract contributions have been recommended by the Postgraduate Foundation Committee.

The Michigan Foundation for Medical and Health Education represents a modern vehicle to extend established and prospective programs in postgraduate and medical education in this state—programs largely pioneered in Michigan

in which the medical profession justifiably may take great pride and enthusiasm.

AID TO MEDICAL VETERANS OUTLINED

Governor Harry F. Kelly, Colonel Philip C. Pack and Major A. D. Alquire of the Office of Veteran Affairs, State of Michigan, met with the Committee on MSMS Medical Veterans' Readjustment Program and with members of the Executive Committee of The Council in Lansing on May 16, to outline plans benefiting Michigan veterans, including medical officers.

A program to grant fellowships of one year to ten psychiatrists, through the co-operation of the University of Michigan, was outlined by Colonel Pack who asked the help of the Michigan State Medical Society's Committee in finding ten doctors of medicine, among returning veterans, who might receive this training. The fellowship includes a \$2,000 allotment for one year with the opportunity of serving an additional year in a state institution. This program was heartily endorsed by the MSMS representatives.

Another project outlined by the Office of Veterans Affairs is emergency hospitalization of veterans. The state agency will reimburse the hospital for its service and for the present will use the prevailing medical fee for private patients in each community as reimbursement for the physician. It was stressed at the meeting that the men and women to be served do not represent an indigent group.

Major Alquire presented the growing need of veterans for affidavits in order to establish service-connected disabilities. "Without these affidavits," stated Major Alquire, "veterans will not be able to establish a status upon which their livelihood for the rest of their lives may depend." The Michigan State Medical Society's Committee recommended that the Office of Veterans Affairs develop a uniform affidavit blank which might be given to the veteran to present to his family physician. A sample of the affidavit form will be published in the *MSMS Journal*, in an early issue.

A booklet to inform medical veterans concern-

(Continued on Page 542)

***Her menopausal symptoms will
respond to treatment with--***

WARREN-TEED Sterilized Solution DIETHYLSTILBESTROL



● Diethylstilbestrol is one of the stilbene compounds discovered by Dodd's and his coworkers to possess estrogenic activity. Its physiological action is similar to that of natural estrogens as manifested by induced estrus and stimulated growth of the endometrium and myometrium.

Diethylstilbestrol is indicated in the treatment of menopausal symptoms, senile vaginitis, gonorrheal vaginitis in children, vulvovaginitis, and in conditions in which an increased amount of estrogenic activity is desired.



Diethylstilbestrol, 1 mg. per cc.
Supplied in 15 cc. vials and in 1 cc.
ampuls.

***Oil resistant, leak-proof,
neoprene stopper and tamper-
proof aluminum seal
protect every vial of
WARREN-TEED
Sterilized Solution***

WARREN-TEED

Medicaments of Exact Quality Since 1920

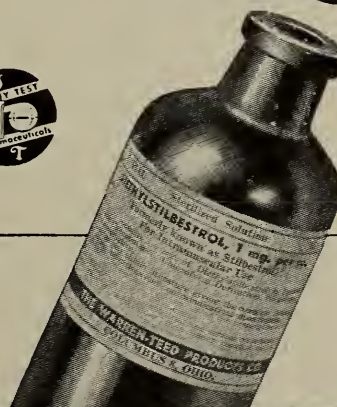
THE WARREN-TEED PRODUCTS COMPANY, COLUMBUS 8, OHIO



Aluminum cap — keeps
stopper clean after
inner seal has been
broken.

Inner aluminum
seal — showing tab
partially removed.

Neoprene stop-
per — oil resis-
tant — will not
deteriorate.



Warren-Teed Ethical Pharmaceuticals:
capsules, elixirs, ointments, sterilized solu-
tions, syrups, tablets. Write for literature.

**WARREN-TEED
STERILIZED
SOLUTIONS**

AID TO MEDICAL VETERANS OUTLINED*(Continued from Page 540)*

ing their rights under the GI Bill (Public Law 346) and under Michigan's Veterans Law (Act 26 of 1944, first extra session) will be developed through the co-ordinated efforts of the Office of Veterans Affairs and the Michigan State Medical Society.

Governor Kelly congratulated the Michigan State Medical Society on its creation of the Medical Veterans' Readjustment Program. "Your program will fill any gap that may exist in the state and federal programs, so far as medical veterans are concerned," stated Governor Kelly. "Your problems are many, especially in postwar postgraduate medical education, and I commend your Society on this forward-looking activity."

INTERIM STUDY COMMISSIONS ON HEALTH INSURANCE

Interim committees to study health insurance and to report to the Legislature in 1947 have been established in West Virginia and in Virginia.

In the State of Washington the Unemployment Compensation Commissioner has been authorized to conduct a study of the same subject for report to the Legislature two years hence.

In New York State a bill was introduced with the avowed purpose of keeping it in committee over the recess during which time it would be discussed and amended as indicated by hearings and studies³ carried on by the committee.

Other States may appoint interim study committees, as certain Legislatures still are in session as we go to press.

Michigan's Legislature did not seriously consider the proposal for health insurance introduced during the last days of the 1945 session. In fact, the bill was never ordered printed, and died in committee. However, the medical profession of this State is not complacent as a result of this easy disposition of such an unfavorable proposal. The doctors of the state recognize the serious threat which this bill presents; they realize they must develop their own and the best program of complete distribution of medical care, and quickly!

The Michigan State Medical Society has its own "interim study commission on health care," better known as the Drafting Panel. This group has developed an Outline with a suggested program of health legislation based on the time-tried

private practice of medicine and the preservation of the physician-patient relationship. A copy of this Outline appears on page 585 and is invited to the careful perusal of every member of the Michigan medical profession.

The voluntary program recommended by the Drafting Panel will be preferred by the people to the imposition of a most objectionable system of compulsory political medicine—*provided the story is told to them*. It is the responsibility of every doctor of medicine to present to the public the salient points of the profession's own plan for better health in America.

THE VOLUNTARY PROGRAM MARCHES ON

Legislative acts authorizing the formation of plans for the prepayment of medical bills, in the manner of Michigan Medical Service, have been enacted in Tennessee, Iowa, Kansas, Minnesota, and North Dakota this year. This brings the total to nineteen states which have approved enabling acts. The bills passed were sponsored by state and county medical societies, and permit the prepayment of medical care and in at least one instance of dental care.

Already serving states or regions are forty-two medical prepayment plans established by organized medical groups.

The medical profession is offering the people something they want, in a better manner than can be done by government with its compulsory, political bureaus.

USPHS INSPECTS MICHIGAN MEDICAL SERVICE

J. W. Mountin, M.D., Chief, Division State Relations; W. P. Dearing, M.D., Assistant Chief, Public Health Methods, and Louis S. Reed, Ph.D., Senior Economic Analyst, of the United States Public Health Service, Washington, D. C., inspected the workings and methods of Michigan Medical Service, Detroit, on May 2. That evening they met with officials of the Michigan State Medical Society, including President A. S. Brunk, M.D., Detroit; Councilor and Editor Wilfrid Haughey, M.D., Battle Creek; Councilor C. E. Umphrey, M.D., Detroit, and S. W. Insley, M.D., Detroit, member of the MSMS Drafting Panel.

"Prepayment medical care plans, such as your Michigan Medical Service, are of extreme inter-

(Continued on Page 544)

"don't smoke"...

*IS ADVICE HARD FOR
PATIENTS TO SWALLOW!*

May we suggest, instead,
SMOKE "PHILIP MORRIS"?
Tests* showed 3 out of every
4 cases of smokers' cough
cleared on changing to
PHILIP MORRIS. Why not
observe the results for
yourself?

*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY
DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

USPHS INSPECTS MICHIGAN MEDICAL SERVICE

(Continued from Page 542)

est to the United States Public Health Service," stated Dr. Mountin, "as they have great possibilities for the extension of medical service."

Discussed were the possibilities of future expansion of MMS coverage, to include eventually direct relief and Social Security categories; further education concerning the advantages of the voluntary program; and the securing of professional support in all areas.

The MSMS group was impressed with the favorable attitude of the USPHS representatives who are well informed on the various voluntary prepayment medical care plans which exist throughout the United States.

WELDING MEDICAL FORCES

Michigan again is to be congratulated upon its unique approach, its forward-looking and aggressive measures, and for the splendid manner in which it conducted this well-planned conference [Conference of Seventeen State Presidents]. It has indicated its progressive spirit, and it has led the way in adopting a positive stand to the end that the principles of American Medicine shall be preserved.—N. K. FORSTER, President, Indiana State Medical Association, J. Indiana State M.A., June 1945.

SOME OF THE BENEFITS OF MEMBERSHIP

The Michigan State Medical Society and its component county societies bring to you these valuable benefits of membership:

1. Assurance of a high ethical standing for you in the community, the State and the nation, before the public, the law, and the profession.

2. Postgraduate courses and lectures to keep you in touch with medical progress and to improve professional ability.

3. Your common interests safeguarded through the vigilant work of democratically selected officers and committeemen who are men of your own kind: (a) who know your problems and those of your patients; (b) who serve generously without compensation; (c) who need and ask for your coöperation and advice.

4. Protection against state and national legislation inimical to public interests and advancement of medical science; constructive efforts to initiate beneficial health measures; important contacts to effect the proper administration of existing laws.

5. Information and technical advice in medical-legal matters.

6. Defense of your profession and your source of livelihood against encroachments from without.

7. Authentic information to an inquiring public regarding good medical service and the standing of practitioners.

8. A monthly JOURNAL of high quality with the latest scientific literature, and general information important to you.

9. Personal service of your Executive Office in Lansing in matters associated with your practice of medicine.

10. Your medical societies act as sales ambassadors of the medical profession in your community and the State.

The returns you receive from Membership in the Michigan State Medical Society are almost unlimited.

Your destiny is intimately related to the success of your county, state and national medical organizations.

SEVENTEEN STATE SOCIETY PRESIDENTS MEET

(Continued from Page 536)

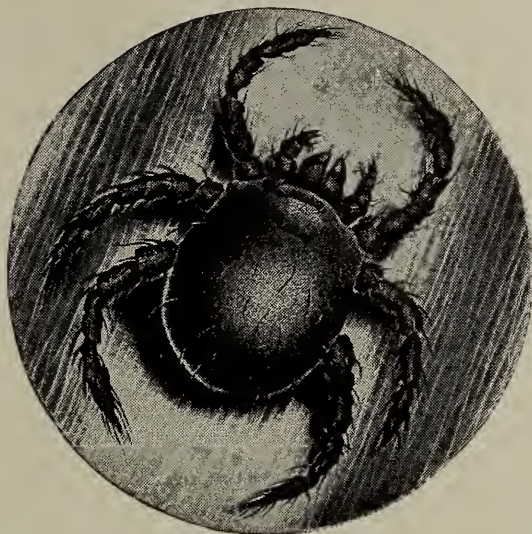
New York, Ohio, Pennsylvania, Rhode Island and Wisconsin.

Medical Society officials at the Conference included: E. J. McCormick, M.D., Toledo, member of the AMA Council on Medical Service and Public Relations; President William Bates, M.D., Philadelphia; President Elmer S. Bagnall, M.D., Groveland, Mass.; President R. D. Bernard, M.D., Clarion, Iowa; President N. K. Forster, M.D., Hammond, Ind.; President E. P. Coleman, M.D., Canton, Ill.; President Elihu Wing, M.D., Providence, R. I.; President F. L. Rogers, M.D., Lincoln, Neb.; President Oscar O. Miller, M.D., Louisville, Kentucky; Acting President Wm. Ballinger, M.D., Washington, D. C.; President E. L. Tuohy, M.D., Duluth, Minnesota; President Charles Fidler, M.D., Milwaukee, Wisconsin; President J. F. Londrigen, M.D., Hoboken, N. J.; President Irving L. Chipman, M.D., Wilmington, Delaware; President H. H. Baucus, M.D., Buffalo, N. Y.; President Jos. H. Howard, M.D., Bridgeport, Conn.; President H. Gildersleeve Jarvis, M.D., Hartford, Conn.; President Howard L. Schriver, M.D., Cincinnati, Ohio; Past President L. F. Donohoe, M.D., Bayonne, New Jersey; OSMA Councilor A. A. Brindley, M.D., Toledo, Ohio; J. B. Lukins, M.D., Louisville, Chairman, Medical Economics Committee, Kentucky State Medical Association; and President A. S. Brunk, M.D., Detroit.

Wyeth

REG. U. S.

PAT. OFF.



Effective Prophylaxis, Efficient Treatment for *CHIGGERS!* (RED BUGS)



NOW'S THE TIME THE TROUBLESOME CHIGGER MITE starts his regular summer offensive!

But he folds up quickly, completely—under the effective action of Sulfur Foam Applicators, Wyeth.

These applicators distribute particles of sulfur evenly, thoroughly, over the body in a most effective medium—bland soap foam.

N. B.: "The superiority of this form of sulfur over powders, ointment, pastes, etc., is without challenge!"*

During the coming chigger season, this timely prescription product will bring enthusiastic thanks from grateful patients!

*Romeo, Z. J.: Sulfur and Soap as Effective Prophylaxis Against "Chiggers" (Red Bugs) in the Army, Mil. Surgeon, 90:437-439 (April) 1942.

WYETH INCORPORATED • PHILADELPHIA 3 • P A .

JUNE, 1945

Say you saw it in the Journal of the Michigan State Medical Society

545

It's The Law, Doctor!

Juris ignorantia est, cum jus nostrum ignoramus—Old Maxim.

NOTES ON COURT DECISIONS, STATUTES AND OTHER AUTHORITIES

Duty of Physicians to Refer Patient to Specialist or to Disclose That Ailment Is Beyond His Ability to Treat Properly

J. JOSEPH HERBERT, LL.B., General Counsel, MSMS
Manistique, Michigan

It is the universal and well-understood rule that a physician is liable to his patient for a failure to exercise requisite skill and care. Included within this general obligation is a duty sometimes overlooked by practitioners of the healing arts. It has been held by courts that as a part of the requirements which the law exacts of general practitioners of medicine and surgery, or other schools of healing, if, in the exercise of the care and skill demanded by those requirements, such a practitioner discovers, or should know or discover, that the patient's ailment is beyond his knowledge or technical skill, or ability or capacity to treat with a likelihood of reasonable success, he is under a duty to disclose the situation to his patient, or advise him of the necessity of other or different treatment.

The supreme court of North Dakota has sustained judgments against physicians based on the breach of this duty. Failure of general practicing physicians for at least twenty-four hours after discovering evidence of the beginnings of a virulent and fast-spreading infection due to hypopyon ulcer of the cornea, following the extraction of a cinder which had become embedded in the eyeball, either to inform the patient of the situation and advise immediate treatment by a specialist in diseases of the eye, or to follow what expert medical testimony showed to be the only course of treatment by which such a practitioner could hope for any eventual success, was held to justify a jury finding that a proper degree of professional care had not been used, in *BEARDSLEY v. EWING* (1918) 40 ND 373, 168 NW 791.

The Massachusetts supreme court in two malpractice cases involving broken arms, held that if the physician had not the requisite skill and experience to treat the patient's condition, he should have temporarily dressed the affected member and recommended the patient to a more skillful surgeon. *SMALL v. HOWARD*, 128 Mass. 131; *MALLEN v. BOYNTON*, 132 Mass. 443.

The same rule has been applied in Missouri in at least two cases which reached the Supreme Court of that state. It was held in the case of *LOGAN v. FIELD*, 75 Mo. App. 594, that if, during treatment, the physician became convinced that the case was one for the attention of a specialist, or his previous treatment definitely had proved and if pursued would be likely to prove ineffectual, his duty required him to disclose his convictions or doubts.

In Michigan the supreme court in 1925 affirmed the same principle. Henry J. Mulder, a chiropractor, was sued for malpractice. He had undertaken to treat a seven-year old girl who was suffering from diphtheria by applying chiropractic methods. The child died about a week after the treatments began. The trial court directed a verdict for the defendant. The supreme court reversed the judgment but, interestingly enough, did not base its conclusions on the fact that the treatment given by the chiropractor was improper or unskillful as judged by doctors of medicine. The court said: "While not registered, the defendant was a graduate of a chiropractic school. He but assumed to treat human ailments in accordance with the system taught in such school. This fact was well known to plaintiff. The burden was therefore cast upon her to show by competent evidence, not only that his treatment was injurious or not effective, but that the requisite care and skill was not exercised by him in administering it. It necessarily follows that such proof must be made by one engaged in treatment by similar methods to those employed by defendant. With the merits of the several drugless systems of relieving human ailments the courts have no concern. It is sufficient to say that many of our citizens believe in their efficacy and secure the services of those engaged in practicing them. The treatment given by any one of such practitioners would probably be deemed improper and unskillful when judged by physicians who are taught to treat such ailments by the use of drugs and medicines. The unfairness of permitting the test as to whether a particular treatment was proper or skillful to be determined by one who uses a different method, or follows the teaching of another system, must be manifest."

Essentially, the court's decision rested on the proposition that a practitioner of the healing arts has a duty to determine whether his skill and training is sufficient to undertake treatment which the case requires, together with the duty to advise the patient that this training and skill are not sufficient to render proper treatment, in the event that he lacks the necessary training and skill. The court said:

"When he undertook to administer treatment to her, he assumed the responsibility of determining whether the treatment he proposed to administer, and afterwards

(Continued on Page 556)

How Long is a good night's sleep?



Four? Eight? Sixteen hours? Eight hours most closely approximate the requirements for normal physiological recuperation. Ipral functions within this range. Given one hour before retiring, Ipral will carry the patient through a full night's sleep, unlike the shorter-acting hyp-

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JUNE, 1945

Say you saw it in the Journal of the Michigan State Medical Society

547

Medical Public Relations

DISCUSSION ON PLANNING PANEL

P. L. LEDWIDGE, M.D.

Speaker, House of Delegates, MSMS

Detroit, Michigan

We in Michigan believe that some changes in methods of medical practice and distribution of medical care are inevitable. We believe that these changes should be evolutionary and guided by the medical profession. We believe that this ideal of controlled evolution is not one to be accomplished easily. We believe that powerful forces are at work bent on revolutionary changes that may completely alter or replace the practice of medicine as a private enterprise. We believe that it is time for Medicine to stop playing a defensive game and start carrying the ball. When Johnny Mercier wrote his popular song he expressed in these few words "Accentuate the positive, eliminate the negative" a philosophy that long ago should have been adopted by organized medicine in dealing with medical economics and public relations.

If we are to preserve the traditional methods of practice and obviate compulsory health insurance, with its governmental control and political implications, it seems to us three things are necessary:

1. We must offer voluntary plans that will give to the nation better physical and economical health than is to be expected from any compulsory plan government may offer.
2. We must sell these voluntary plans to the public.
3. We must sponsor and effectuate the passage of legislation that will put these plans into operation.

The first of these three objectives has been partially accomplished in Michigan by Michigan Medical Service, a project you will have an opportunity to study first hand this afternoon. I am sure that Dr. R. L. Novy, President, and Mr. Jay Ketchum, Executive Vice President, respectively, of Michigan Medical Service will have many things to show you that will be both interesting and informative. We have made a start toward the second objective through our radio program, under the chairmanship of Dr. Clarence L. Candler, that will be demonstrated and discussed with you this evening. The time seems ripe to attempt our third objective. Someone has said, "There is nothing so irresistible as an idea whose time has come." The time for health legislation is here. There is abundant evidence that bad health legislation is being offered. The Wagner-Murray-Dingell Bill, rejected by Congress in 1943, is now in the process of revision and revival. The number of proposals for some form of compulsory health insurance at the State level is increasing by leaps and bounds.

Discussion at the Conference of Seventeen State Medical Society Presidents, at Detroit, April 27, 1945.

Since 1935 one hundred such proposals have been introduced into the legislatures of various states. Thirty-four of these, a little more than one-third, have been within the last year. Twelve of the sixteen states represented here today have had such proposals. *The time for health legislation is here.*

Right now we have an unusual opportunity for good legislation. It so happens that a member of the Council of the Michigan State Medical Society is the personal physician and very close friend of one of the strongest legislators in Congress. A few weeks ago, following a long heart-to-heart talk between these two gentlemen, we were advised by our Councilor that he believed this legislator could be prevailed upon to work with us on a health measure. We are certain that in saying this, our Councilor made a very conservative statement. We are confident that this distinguished legislator is not only willing but anxious to draft and introduce into Congress proper health bills, embodying the constructive thought of the medical profession. Recently in discussing this happy circumstance with a medical leader from one of our sister states, we were delighted to learn that the ranking United States Senator in that state had indicated a similar willingness to co-operate with their medical society on health legislation. Since then the chairman of our Council, Dr. Edward F. Sladek, has appointed a planning panel to lay the foundation for such health bills. It is not the purpose of this panel to draft legislation but rather to set down in orderly fashion, for use of those who do the drafting, sound principles and specific recommendations based on our experience and pertinent to the welfare of the people. The panel already has held two meetings.

No doubt this "irresistible" idea of good health legislation is being entertained by Congressmen from other states. It is with these things in mind that we now lay the matter before you for discussion, in hopes that each of you in his own state will act as an organizer in setting up planning panels, to the end that medical thinking on health legislation on a nation-wide scale may be crystallized. We invite you to join in this work. The task is a tremendous one; the time is propitious; the need is great. Let's all get together and do something constructive.

N. K. FORSTER, M.D.

President, Indiana State Medical Society
Hammond, Indiana

In the face of the many economic and legislative matters that are confronting the medical profession today the demand for better medical public relations, heard all over the country, should be of primary interest to all of us. It springs from a belated recognition

(Continued on Page 550)

WHEN FORMULAS MUST BE "TAILORED TO FIT"



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DISCUSSION ON PLANNING PANEL

(Continued from Page 548)

of the fact that, in a world of high-powered propaganda, it is necessary to seem right as well as be right.

It is correct to say that no other group can match medicine's record of devoted service to the public good. Yet, today, even in the field of healing, other voices take precedence over the doctors'.

The reason, of course, is that physicians have been too preoccupied with extending and applying their professional knowledge to explain the why and wherefore of their activities to the public. To all too many laymen such patent diagnostic and therapeutic media as the x-ray, the electrocardiogram, the sulfonamides and penicillin are wonders wholly apart from the physicians who employ them and without whom they would be useless or even dangerous instrumentalities. This tendency to "play down" the doctor is even more marked in the field of medical economics, where pressure groups ignore and distort history to depict the profession as selfish and shortsighted.

Important as public relations experts are in achieving more and better public confidence and relations, they do not relieve the individual practitioner of the duty to carry on his own private campaign.

We are medicine's public relations men, so far as our individual patients are concerned. If they show interest in medical social and medical economic issues, we should take the time to explain medicine's attitude to them. Show them the stake they hold in the maintenance of the existing system of medical practice. And, above all, we should exemplify the best traditions of medical science and ethics so that no amount of adverse propaganda can alter the picture they know to be true.

Having gotten that preliminary statement off my chest, I want to make a few assertions and one definite recommendation.

1. I think that, so far as our relations with the public are concerned, they are deplorable.
2. Your own survey, and others, clearly indicate that a definite proportion of the people want some sort of insurance protection against the hazards of illness.
3. A certain percentage of them are willing to accept government supervision of their health needs.
4. A large group of people are willing to forego the physician-patient relationship and accept the services of governmentally regulated medical care.
5. The medical profession, as a whole, has offered no comprehensive plan to adequately service this minority group.

I think that Michigan is an outstanding example of what may be accomplished, through concerted action, to solve the problems confronting us. But Michigan, alone, cannot answer the problem of sickness insurance care throughout the nation. Neither can any experimental county or city group provide the answers.

We need, and we must have, the combined efforts of the *entire* medical profession to solve, and present to the people, the unified, concerted answer to the problem confronting them. With the advent of so many diag-

nostic measures now employed it has become a great financial hazard for anyone to become ill. Such measures and methods should be universally available to all the people at a cost which they can afford.

I am not going to decry the efforts of the A.M.A. Council on Medical Service and Public Relations, because this body, made up of practicing physicians, is devoting endless time and effort in the attempt to solve our problems. But I am going to say this—that, up to now their efforts have accomplished exactly—nothing.

They have formulated no plan—they have *not* benefited our public relations. They have not offered the public anything to hope for—they have not presented anything constructive for the profession to get behind and cheer about. There is nothing personal in these remarks—I have the utmost confidence—as you have—in the ability and the sincerity of the members of this Council—and we know that they are trying to do a good job.

Gentlemen, the fact remains that they are expending their efforts in a futile approach. Doctors of medicine, as now organized, have neither the time nor the perspective to visualize or accomplish the things that must be done to afford adequate medical services, in the sense of a comprehensive plan, or to promote good public relations in the sense of an outstanding presentation to the people of the good goods we have to sell.

My one definite recommendation is this: To set up a leadership in the field of medicine in the person of an outstanding figure in public life, such as Eric Johnston or J. Edgar Hoover or anyone of similar caliber whose function would be to establish definitely good medical practice throughout the nation and then promote this practice to the people in the form of a service that could not be questioned. Unless, and until, we adopt some such measure our relations with the public are likely to remain subject to the inroads of governmental propaganda and our services subject to bureaucratic domination.

For Indiana, and particularly for myself, I want to attempt to express the appreciation I feel in having been invited to attend this meeting. Secondly, I want to congratulate Michigan on this ambitious and forward-looking program we have heard about tonight.

I believe it would be most unfortunate if some definite action did not come out of this meeting and therefore I would like to make this motion. (See Editorial, page 585.)

WOMEN MEDICAL OFFICERS

Seventy-four women medical officers have been commissioned in the Army; four are Majors, 36 are Captains and 34 are First Lieutenants. They have been assigned by the Army to duty at general regional and station hospitals and two WAC training centers, and have been certified as internists, neuropsychiatrists, obstetricians, gynecologists, radiologists, pathologists and anesthetists. Seventeen are serving overseas.

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War Medicine

EDUCATION OPPORTUNITIES FOR ARMY DOCTORS

Since the start of World War II, over 6,000 selected medical officers have been graduated from short but intensive courses given by the Medical Department in some thirty critical medical and surgical specialties, according to Major General George F. Lull, Deputy Surgeon General. In addition, refresher courses in general medicine and surgery provide medical officers with a chance to "brush up" before returning to professional assignments after other duty.

Many doctors also benefit while in service from working under key professional personnel in military hospitals. Other medical officers who have been on duty with combat troops in the field are given an opportunity to brush up on their specialty through the rotation policy.

General Lull reported that 350 doctors have been reassigned from field to hospital duty during the past year in the Mediterranean Theater and "the merit of intra-theater rotational plans has been pointed out to other theaters, and is being encouraged in order that the maximum number of doctors might receive refresher training while they are still in military service."

Naturally, professional training of medical corps officers during military service must be restricted to meet military rather than civilian requirements. However, the Surgeon General is keenly interested in the welfare of these doctors and will provide "insofar as is possible" opportunities for professional training.

In the postwar period, all doctors will be entitled to professional training, after their release from service, under the GI Bill of Rights, and those who remain in the Army will have the opportunity for refresher training at selected military hospitals and civilian schools.

EXPENDABLE REFRIGERATORS PROLONG LIFE OF WHOLE BLOOD

Whole blood, flown from this country to the European Theater of Operations, keeps in condition for transfusions 5 days longer than formerly, or as long as 21 days, because of a new system of refrigeration inaugurated this month, according to the Office of the Surgeon General.

The bottled blood is now being flown overseas daily in compact, expendable ice boxes made of metal foil on cotton insulating board which keep the blood within safe temperatures: between 39 and 50 degrees Fahrenheit. The containers, measuring 21 x 21 x 25 inches, weigh only 105 pounds when carrying their full capacity of 24 bottles. Each bottle contains about a pint and a half of whole "O"-type blood.

An elaborate system has been set up overseas to complete delivery. The blood is flown to focal points in all forward areas. Blood bank detachments at these points service all Communications Zone medical installations in the area and truck the blood farther forward to ad-

vance detachments which deliver it to the operating surgeons.

NEW TYPE AMBULANCE

An improved ambulance, which will carry twelve instead of four litter cases in greater comfort, has been developed at the request of the Surgeon General by the Ordnance Department in collaboration with the Army Medical Department. By May 31 twenty-five of these new ambulances were carrying casualties from ships and planes to Army Hospitals.

The new ambulance has an aluminum body with a front wheel drive which allows the bed of the truck to be placed lower, making it easier to move patients in and out. It is smoother riding than the old type and provides such refinements as a heater for use in cold weather, roof ventilating fans to keep the air fresh, window shades to provide privacy in traffic and individual electric lights over each litter. There are ample compartments for bedding and utensils. A comfortable seat is provided the attendant next to the driver. Both sit enclosed with the patients.

GLIDERS CARRY WOUNDED TO HOSPITALS

A glider service was inaugurated in the European Theater this month to evacuate our wounded from Remagen. Observers reported that the shock incident to being "snatched" into the air was absorbed by an improved towing device. It is now possible that gliders may almost eliminate ambulances for hauling our battle casualties long distances over shell-torn roads—giving them a faster, smoother ride to the hospital.

The gliders serve a dual purpose. Coming into the battle area they can carry twelve litter patients or nineteen walking wounded.

Ambulance gliders were first used experimentally by the British in Burma and New Guinea.

NEED NOW IS FOR 16,000 NURSES

The Army needs 16,000 additional nurses immediately in order to care adequately for wounded and sick American soldiers, according to Major General George F. Lull, Deputy Surgeon General.

During the first two weeks of February, 1,450 registered nurses received commissions as officers in the Army Nurse Corps. This is an increase over the 1,050 commissioned in January, but the total number of nurses is still far short of the Army's immediate needs.

With the flood of new patients from overseas, the authorized ceiling for the Corps was recently raised from 50,000 to 60,000. At present it numbers only 44,000 and about 250 nurses a month are separated from the

(Continued on Page 554)

The Flying Capsules



R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

Now in use on the battle fronts, for speedy evacuation of wounded from nearly inaccessible areas, is this Helicopter with "capsule" stretchers attached to sides



WHEREVER our soldiers are fighting, Army medical men have established a speedy life line for wounded. So fast and so efficient is it that often the wounded are under the care of skilled medical officers *within a matter of mere minutes!*

In this stepped-up tempo of war, however, the Army doctor finds little "time out" for himself. When there is a "break" in his long hours, his relaxation may be limited to a few pleasant moments with a cigarette... very likely a Camel, for Camels are such a big favorite with men in all the services.

Camel

—costlier tobaccos

NEED NOW IS FOR 16,000 NURSES*(Continued from Page 552)*

Army for various reasons. About 71 per cent are overseas, some having been in foreign theaters for several years. Incidentally, a more effective rotation plan for these overworked nurses will be possible when the full quota of 60,000 is reached.

GENERAL KIRK COMMENDS INFANTRYMAN

A soldier had received a wound in the neck over the tracheal area. He was turning blue in the face, gasping and apparently suffocating from the injury to his windpipe when T/4 Duane N. Kinman, then a private in the 5th Infantry Division fighting in Germany, reached his side. Remembering the lectures he had received on the care of such a wound, Kinman whipped out his jackknife, opened the windpipe, and used part of the wounded man's fountain pen as a wedge to keep the wound open to prevent suffocation. For his prompt and skillful application of his "medic" training, the following personal letter of commendation was forwarded T/4 Kinman from Major General Norman T. Kirk, The Surgeon General:

"I have noted with pleasure recent publicity concerning your courageous act on the field of battle when under the most difficult of situations you saved the life of a fellow soldier by performing an emergency tracheotomy.

"Your actions under the circumstances were in accordance with the highest standards of the medical soldier and reflect credit on the training, calibre, and resourcefulness of the enlisted men of the Medical Department, U. S. Army.

"May I also congratulate you on the offer of a medical education made by the President of Western Reserve University, according to newspaper reports."

This exploit has been widely advertised, and the editors excuse for repeating it is the fact that T/4 Duane N. Kinman belonged to Major Wilfrid Haughey, Jr.'s, Battalion of the 10th Infantry.

193,000 PINTS OF BLOOD FLOWN TO WOUNDED

Combined figures on East and West Coast flights of whole blood to the war theaters reached 193,000 pints in March according to the Office of The Surgeon General. Since the start of the blood-flying program over the Atlantic last August, 150,000 pints of whole blood have been flown from the East Coast to the European Theater. This service has made it possible for a wounded man to get blood within 24 hours after it was drawn from a donor here. Shipments now average about 1,200 pints a day—which provides transfusions for three to four hundred average cases.

Whole blood shipments being flown from the West Coast to the Pacific Ocean Area have totaled 43,000 pints since the inauguration of the service last November.

Continued donations of type "O" whole blood are necessary to maintain this life-saving service.

COMBAT BADGE FOR MEDICAL PERSONNEL

A special badge has been authorized for Medical Department personnel who daily share with the infantry the hazards and hardships of combat. Made of silver the Medical Badge is elliptical in shape with the caduceus and the Geneva Cross superimposed on a litter surrounded by a wreath of oak leaves. It is to be worn on the left breast above decorations and service ribbons.

The badge was established in recognition of "the important role being performed by medical personnel on duty with infantry units, especially infantry battalions." Enlisted and officer personnel below field grade (major) and regimental surgeons regardless of rank are eligible for the badge if they have seen combat service with the infantry since December 7, 1941.

MOBILIZATION AGAINST JAPAN

The Joint Chiefs of Staff have made a preliminary estimate of the troops and equipment needed to crush Japan in the shortest possible time and with the smallest cost in American lives. Our Army is now 8,300,000 strong. Military judgment is that we can defeat Japan quickly and completely with an Army which a year from now will be 6,968,000. Every physically fit soldier in the United States who has not yet served overseas will be assigned to foreign duty when he completes his training or, if he is performing an essential administrative or service function, as soon as he can be replaced by a returning veteran.—FRED L. CRAWFORD, MC, Michigan.

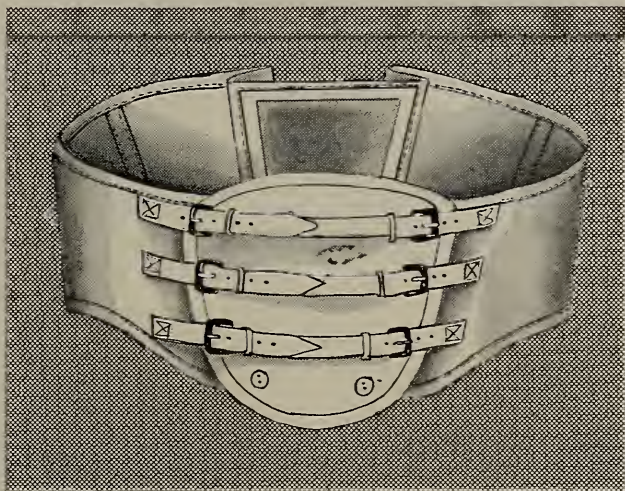
MEDICAL INDUSTRIAL CONFERENCE*(Continued from Page 536)*

Arbor; H. F. Robb, M.D., Belleville; K. E. Robinson, Lansing; A. L. Brooks, M.D., Detroit; H. Graham Ross, M.D., Montreal, Canada; Theodore P. Ryan, LL.B., Lansing; C. O. Sappington, M.D., Chicago; C. D. Selby, M.D., Detroit; Lowell S. Selling, M.D., Detroit; J. H. Selman, M.D., Detroit; Allen Shoenfield, Detroit; Ruth N. Simons, Detroit; W. J. Smale, Detroit; B. R. Springborn, M.D., Detroit; Emory W. Sink, M.D., Ann Arbor; A. R. Smeck, M.D., Detroit; Gale C. Smith, Detroit; Hilda Smith, R.N., Detroit; John C. Soet, Lansing; Louis J. Steiner, M.D., Detroit; Harry L. Stern, M.D., Detroit; J. O. Thomson, M.D., Grand Blanc; W. A. Thompson, M.D., Detroit; Miss Marguerite Tourre, R.N., Muskegon; Floyd R. Town, M.D., Lansing; Arch Walls, M.D., Detroit, and F. R. Walters, M.D., Battle Creek.

Major Roy P. Warren, Sn.C., AUS, Baltimore, Md.; W. Mark Wendt, Detroit; Earl E. Weston, M.D., Detroit; Albert R. White, Detroit; Frank J. Wirken, Lansing; William N. Witheridge, Detroit; G. H. Wood, M.D., Onaway; Clarence E. Wormuth, Detroit; Eugenia Zasada, Detroit; Joseph L. Zemens, M.D., Detroit, and Mary Alton, R.N., Lansing.

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Political Medicine

THE LABOR VIEWPOINT

The following editorial printed in a recent issue of *The Labor Union*, at Dayton, Ohio, daily owned by local unions affiliated with the American Federation of Labor, is significant at this time when there is renewed agitation in Congress for the passage of some type of bill similar to the Wagner-Murray-Dingell Bill (S. 1050):

"At a time when medical science is performing seeming miracles in the discovery and application of new healing agents and operating techniques, and while thousands of American doctors are away in the armed forces serving America and all mankind, along comes this proposal to socialize medicine, as part of a broad scheme to provide 'security' for the general public.

"The Constitution of the United States gives every man the right to 'his day in court,' before he can be 'counted out' of circulation with his fellow men, although he may be known to be a criminal. But is the medical profession of America being given its 'day in court'?

"Those members of the medical profession who are risking their own lives on the far-flung battle front of the world in behalf of your fathers, sons, or sweethearts—yes, and of thousands and thousands of the womanhood of America, since women are now in every branch of the service—do not have the time nor opportunity to protect themselves from this 'stab-in-the-back,' which the Wagner Bill undoubtedly is."

* * *

The small force of physicians and doctors left in the United States to look after all the millions of war workers and to try to keep the nation in as healthy a condition as possible, are little if any better off than those outside our shores with regards to time to look after their own welfare and the protection of their profession.

Thus it behooves every worker to do all possible to protect his own interests and those of his doctor by fighting this dangerous Wagner Bill, which is Senate Bill 1161.—WEST VIRGINIA MEDICAL JOURNAL, April, 1945.

MICHIGAN'S STATE MEDICAL BILLS

S.B. 362 (same as H.B. 423) is the so-called "people's health act." This provides for a scheme of compulsory state health insurance. As gathered from the declaration of policy appearing in section 2 of the bill, the measure is based on the false premise that the only way in which the public is to obtain the benefit of medical science is through collectivism and government control. The operation of the scheme is to be in the hands of political appointees, very few if any of whom are to be doctors of medicine. Unless one is to assume that this is the ideal approach to the better distribution of medical care, there seems little advantage in discussing the minute details of administration of this monstrosity.

In a recent editorial by Malcolm W. Bingay entitled "Gallopings Reforms," pertinent reference is made to the question of state medicine. Writing shortly before the introduction of these two bills, Mr. Bingay says:

"Now the battle is on to take over the practice of medicine. There are many faults in the present medical setup as all good doctors know. But as we lost the golden eggs of temperance by killing the goose, are we not in danger of setting back medicine by trying to force reforms in the hands of people who know nothing about the subject or know too much that isn't so? One would think, to hear the advocates of government-controlled medicine that no advance has been made in the healing arts under our present system. . . . "The medical profession has made strides equal to those of any other group and vastly superior to any development in the science of government. Will that advance continue if Congressman Joe Doakes, in return for a political favor, can get his uncle Willie—who used to be the Indian in a patent medicine show—an important job in the bureaucracy which is to regiment the physicians?"

IT'S THE LAW, DOCTOR!

(Continued from Page 546)

did administer, was such as might reasonably have been expected to afford relief. To so determine, it was incumbent on him to use reasonable care and skill to ascertain whether the ailments were of the class to which his treatment applied. If not, it was his duty to so advise plaintiff, in order that she might secure the services of one familiar with such ailments. He admits that he made no effort to do so, although informed of facts as to her condition which plainly imposed the duty upon him." *JANSSEN v. MULDER*, 232 Mich. 193.

It is to be particularly noted that although the Mulder case, supra, involved a chiropractor, the rule applied was the same as that applied to doctors of medicine in other jurisdictions. It may, therefore, be fairly concluded that should an appropriate case come before our supreme court, the same rule would, in all likelihood, be made applicable to doctors of medicine.

RESEARCH ON BLOOD VOLUME

A grant of \$3,200 has been made by the Upjohn Company to Wayne University College of Medicine for the study of blood volume and metabolic changes in cardiac patients. The work will be under the direction of Dr. Gordon B. Myers, Professor of Medicine, and Dr. Samuel Jacobson, assistant instructor in clinical medicine.

"The greatest need for calcium and phosphorus is during the period of skeletal growth."

Stearns, G., JI. Lancet, 63: Nov. 1943

Absorption of these vital minerals is inefficient in humans and often non-effective without the aid of vitamin D.

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REFERENCES:

- Rambar, A.C., Hardy, L.M. and Fishbein, W.I.: J. Ped. 23:31-38 (July) 1943
Wolf, I.J.: J. Ped., 22:707-718 (June) 1943
Wolf, I.J.: J. Ped., 22:396-417 (April) 1943
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Editorial Opinion

A FRIEND IN NEED

We are pretty blue today. Every physician has his sorrowful experiences but we have just had a streak of them, situations in which we feel so helpless yet so honored. Three times in the last five days we have been called to a home where a representative of the Western Union had just left a telegram from the War Department.

We all have read the war correspondents' descriptions of the battlefields of our Army, Navy and Air Corps. The dirt, the mud, the pain, the wounded, the dead, the refugees, the bravery, the hard work, the unselfishness and the sacrifice of the war can be written in a variety of moods. But nothing can compare to the picture of the mother who has just received the word that her son has just paid the supreme sacrifice for his country. All the prayers that she has prayed and all the hopes she has held are suddenly for naught. When her son entered the armed services, she knew that this moment might arrive. Now it is here. Hysterical and griefstricken from the sudden shock of the news, she sits in a daze, wondering if the telegram can be true. Members of the family have gathered around her but in their own grief they can offer her small comfort. In despair, they turn to someone who might help lessen her burden.

Whom do they turn to? The family physician.

We know of no tougher assignment for the physician. There is no drug or surgery that will cure this case. His first impulse is to duck the call, but when he considers the trust his family puts in him, even to the point of sharing their sorrows with them, he cannot refuse the call. The family knows there is nothing he can do to void the news but they feel that just his presence and the few words he may say may tide over those first few hours of grief. Sure he might give a sedative but that is not what counts. It is the thought that "Doc" is a fellow they can trust someone outside the family (not a sympathetic or maybe curious neighbor), someone who is both a friend and confidant, who is a realist, who knows this is an act of the Supreme Being, but who also knows the pain and sorrow that goes with such a happening and so knows just what to do and how to help. What an honor to be called under such circumstances.

May the practice of medicine be ever so—with complete faith between physician and patient; a service of mutual understanding, honor and trust, not dollars and cents and mandatory laws.—W. B. HARM, M.D., *Detroit Medical News*.

HOME FRONT DOCTORS

All of the casualties of war do not occur on the battlefields . . . physicians and surgeons who have been left to safeguard the health of those on the home front are undergoing unusual strain. The stress of wartime

conditions at home creates an added demand on the services of the medical men which might be difficult to meet even if the ranks of the doctors were at full peacetime strength. The situation is made greatly more acute by the fact that the ranks of the doctors have been seriously thinned by requirements of the armed services. . . . It is apparent that under such conditions many doctors have little time for rest from their arduous duties. The crowded waiting rooms of the doctors' offices and the long hours during which they must remain on the job are evidence of the heavy burden they are carrying and of their conscientious efforts to cope with an extremely difficult situation.

They are evidences, too, of the importance of co-operation on the part of all which will enable hard-pressed doctors to go as far as possible to meet the wartime demands upon their skill and their energy.—*Lansing State Journal*, December 22, 1944.

John Wesley Clay of Winston Salem in "My Notions," January 19:

"Time was when typhoid fever was an annual scourge in these parts. Hardly a family escaped its ravages. The victim would languish for days with a burning fever, his strength would ebb away, and after suffering from one to two weeks would either die or recover, sometimes remaining a semi-invalid for a long time. The disease was no respecter of persons. It attacked the robust and strong as well as the physically weak.

"But thanks to the modern doctor, typhoid fever has been put to rout. One of the greatest sources of income to the old-fashioned family physician has been done away with, by the doctors themselves, in the elimination of typhoid fever.

"That is one of the reasons why we hold the medical profession in such high esteem. Disease is bread and butter to the physician, yet he deliberately kills his source of income. They are among God's noblemen. We would hate to see government or politics interfere with this brilliant and noble class of men."

The *South Carolina Medical Journal*, discussing the article in *Collier's* (Jan. 27, 1945) comments:

"And a report from the British Medical Association on the White Paper proposition includes these observations:

"The medical profession will resist any control by the State, either political or administrative, which is inconsistent with their intellectual and professional freedom. They fear political influence on medical matters. They fear bureaucracy and red tape. They fear subservience of the clinical to the administrative."

"Do these quotations support Miss Porter's statement that 'The organized doctors of Great Britain strongly favor more, rather than less, compulsory insurance?'"

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A Proposed Medical Care Program by Medical Co-operatives

■ THE medical men of Michigan, through their development of Michigan Medical Service and other related activities, stand today several years ahead of most other states in their medical economic experiences. Because of this situation, there have been numerous recent requests to these Michigan physicians for a statement of their position on medical-care programs; a statement which could be used as a basis for pending voluntary medical-care programs and for future legislative action, if and where necessary.

The accumulated experiences of Michigan physicians include the precessing of approximately one million persons on a medical-care prepayment plan—a voluntary free enterprise program with freedom of choice by the public of their own physicians and by retention of initiative and enterprise by the doctor himself.

We submit the following points:

1. A medical-care program to be successful must be a program which can offer *good* medical care to *all* the people.
2. It should be a program based on broad liberal Americanism and not confined by the dictatorial tenets of national socialism or of compulsory communism.
3. It should be a program built upon a group-co-operative effort on the part of medical men and one that will fit in with the aspirations of the medical public; in short, an economic picture of various medical-care producers' co-operatives and of medical consumers with the accent on free-will, enterprise and conscience. It is our thought that voluntary medical pre-payment plans, if allowed to flourish, can well cover the large majority of our total population. The remaining of those in total or partial need of medical necessities (and quite likely in need of other necessities), can be adequately taken care of by consumer subsidies.
4. It is our belief that the Federal Government in this medical instance can do best by the encouragement of state-wide co-operatives through either loans or tech-

Prepared by the Drafting Panel. Written by S. W. Insley, M.D., Detroit. Approved by the Executive Committee of the Council, Michigan State Medical Society.

nical aid and reserve their outright cash grants to the purchase of medical care certificates for those unable to purchase their own prepayment security. Any other approach, under whatever terms, becomes an extracurricular government activity and is but the first and determining step down the very short road to federal serfdom.

5. We call attention to the use of medical and hospital co-operatives in the postwar care of veterans and their families. It is our experience and the opinion of surveys that most of these men and their families would appreciate medical care in their local communities with doctors and hospitals of their own choice, with no social service rigmarole and with no stigma of a means test. It is our outright opinion that medical care for veterans and their families can be solved in the American fashion by the use of medical co-operatives with a grateful government subsidizing their payments, if and where necessary.

6. There is a definite shortage of hospital beds in both rural and urban areas. Federal aid may be required to correct this deficiency but it is our opinion that we should provide, insofar as possible, for the eventual local control and management of such institutions.

7. A free choice of physician by the individual patient is one of the intangible factors tending to the improvement of medical care. We also endorse a fee-for-service basis of payment to the doctor so as to further preserve the benefits of competition and of maintaining the quality of service.

Patients should be covered by a *service* contract in contra-distinction to a cash indemnity plan.

Premiums and service benefits can be adjusted to various communities or to any economic group.

8. Medical-care co-operatives (producers' type co-operatives) can and should be set up in every state. They may be incorporated either under special state enabling acts or by already existing state statutes relating to non-profit producers' co-operatives. Any and all co-operatives of the medical-care type must be on a non-profit basis.

It should be recognized that if fortuitous surpluses should be built up over and above prudent reserves, that they then should be available for either broadened benefits to the consumer, to research, public health education or for postgraduate programs, any and all of which is to the ultimate benefit of the medical public.

This recommended program is entirely compatible with the continuation of adequate teaching and research material.

SUMMARY

The above points and discussions are the results of Michigan's actual experiences in the development of a medical-care co-operative. There have been, in addition, the often correlated contacts with public groups, public agencies, economists and others which round out the philosophy and logic of our position.

Our conclusion is that medical-care co-operatives, similar to "Michigan Medical Service," is the American answer to group medical care. It is well constructed to handle the general medical public on a voluntary basis as well as to fit in with public aid programs to special groups by means of consumer subsidies where needed.

As a matter of fact, medical men and hospitals could function efficiently at all economic levels, and in an American way for American needs, with but minimal alterations to the present Social Security Laws.

Some Organic Digestive Disturbances in Early Life

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This paper is concerned with chronic wasting and disturbance of nutrition, associated with foul stools and loss of fat and nitrogen in the feces. The causes of this disturbance of nutrition include diseases of the pancreas and of the intestinal tract and the attachments of the digestive tract. Differentiation of these organic disturbances from somewhat similar disorders of functional nature can be made and is necessary if correct treatment of these serious disorders is to be applied. The relation of the underlying pathologic processes to obstruction of the intestine in the newborn and to a generalized disease involving many organs in the body will be described. Application of these studies on infants and children to similar, and in part unrecognized, disturbances of nutrition in adults will be stressed. A logical classification summarizing present knowledge of the nature and diagnostic characteristics of these organic digestive disturbances with specific indications for their treatment will conclude the paper.

DIGESTIVE disturbances of organic nature are common in infants and children. The remarkable advances in the surgical treatment of many of these belong to the great accomplishments of our time. These advances were founded on recognition of the fact that many gastrointestinal disorders in the newborn, the infant and the child are caused by organic disease which can be corrected only by surgical intervention.¹¹ Brief mention will be made of some of these before turning to other considerations. Congenital malformations of importance include atresia or stenosis of the gastrointestinal tract at any level between the esophagus and the rectum, anomalies of the mesenteric attachment, malrotation of the intestine and colon, duplication of the intestinal tract at any level, imperforate anus, and Meckel's diverticulum. Malformations outside of the alimentary tract proper, such as annular pancreas or mesenteric cyst, may produce digestive disturb-

ances by mechanical means. Meconium or intra-uterine peritonitis secondary to the extrusion into the peritoneal cavity of meconium following perforation of the bowel before birth, is responsible for dense adhesions between loops of bowel and serious interference with the movements of the intestines. Hypertrophic pyloric stenosis still remains an organic disease demanding surgical treatment, at least in Boston, despite increasing discussion of the medical treatment and cure of this condition. Evidence obtained from days before the simple technique of pyloromyotomy had been adopted, when gastroenterostomy was the treatment of choice, showed persistence of the tumor mass in the pyloric wall years later. Malignant tumors in the gastrointestinal tract of infants and children are rare. Most of the small number encountered belong to the lymphosarcoma group. We have studied only one example of an adenocarcinoma in the intestinal tract of a child, and that was in a twelve-year-old boy who for some years had suffered from ulcerative colitis. Polyps, particularly in the rectum, are relatively common and occasionally may be found throughout the entire colon to the number of several hundred. Occasionally, foreign bodies, such as hairballs, are encountered. Regional ileitis or intestinal sarcoidosis occurs but rarely in early life. Preceded by months of diarrhea or constipation which leads to wasting and interference with growth, intestinal obstruction eventually is produced by the marked narrowing of the lumen at the lower end of the ileum. Intussusception usually without a demonstrable cause, and volvulus remain important causes of acute intestinal obstruction in early life. Appendicitis and peritonitis of bacterial origin are the commonest organic digestive disturbances of surgical nature. The action of specific bacterial invaders, parasites, viral agents, and enterotoxins in the production of organic changes in the intestinal tract is well known.

Three diseases with structural alterations in the digestive system of unknown etiology but associated apparently with functional or neurogenic factors may be mentioned briefly. Gastric or duodenal ulcers of the peptic type found in adults are rare but may be fully developed in an infant of even three weeks of age. They may be accompanied even at that age by severe vasomotor instability and other evidences of autonomic imbalance. Ulcerative colitis is encoun-

¹¹ Read before the Fourth Annual Postgraduate Conference on War Medicine, the Seventy-Ninth Annual Session of the Michigan State Medical Society, at Grand Rapids, Michigan, September 29, 1944.

tered frequently enough in infants and children to constitute an important problem. We have seen ulceration of the entire colon extending up to and including the appendix in an infant who died at the age of two months after having exhibited evidences of severe nutritional disturbance since shortly after birth. Associated with this disease in infants there may be marked vasomotor instability. Failure to find convincing evidence of a specific infectious agent as a cause of this extraordinary disease and the numerous evidences of derangement of the autonomic nervous system have led to a search for the cause of the disease in this direction. Indeed, pathologic changes similar to ulcerative colitis have been produced experimentally in the dog by the use of cholinergic drugs.¹⁴ A marked structural abnormality of the bowel which has been explained on a neurogenic basis is megacolon (Hirschsprung's disease.) Law has summarized in a recent study the evidence in support of the neurogenic theory of megacolon as a functional imbalance of the autonomic nervous system supplying the colon and has outlined a rational plan of treatment based upon this theory.¹² Further studies along the lines suggested by these observations on ulcerative colitis and megacolon in early life should be rewarding in a search for mechanisms responsible for such severe organic digestive disturbances.

Chronic disturbances of nutrition associated with wasting, failure to gain, interference with growth and disturbances in the intestinal tract characterized by diarrhea or the passage of foul stools, often greatly increased in bulk, form an important chapter in the diseases of early life. For many years grouped together under the name *Gee's disease* and called variously by a series of names during the last fifty years, including the *celiac syndrome*, such chronic disturbances of nutrition are now known to form part of a number of different disease states. Among the causes of the celiac syndrome most commonly encountered are infections, usually parenteral in location, congenital malformations either of the gastrointestinal tract and its attachments or of the genitourinary tract, diseases of the pancreas which are responsible for an insufficient amount of pancreatic enzyme activity in the duodenal content and a number of conditions of as yet undefined etiology, such as idiopathic celiac disease.

Celiac Syndrome.—To the features of the celiac syndrome which have been well defined clinically since the classic description of Gee in 1888, other findings may be added since they are made so frequently as to be considered characteristic of this condition. These include "clumping" of barium in the small intestine and a low rise of vitamin A in the blood during the vitamin A absorption test. Golden has shown that up to the age of one month and often up to four months of age the small bowel pattern and the motor activity of the gastro-intestinal tract may be identical with, or very similar to those in an older child with a serious nutritional disturbance.¹³ In older children, roentgenologic examination without barium shows an excessive amount of gas in the small bowel. With the aid of barium there are alternating areas of hypertonicity and segmental dilatation of the small bowel so that the column of the barium is broken and shows what is called "clumping." Neuhauser has concluded that these changes are not diagnostic of any one of the causes of the celiac syndrome but their presence should warn of the necessity for further clinical and laboratory investigation.¹⁵ The low rise in the level of the vitamin A in the blood during the vitamin A absorption test is evidence of malabsorption in the intestinal tract but is not characteristic of any one of the causes of the celiac syndrome. Let us begin with a discussion of idiopathic celiac disease. Thought now to be identical with nontropical sprue, this is a benign disease of unknown cause. Symptoms are limited usually to the gastrointestinal tract and to the effects of the chronic disturbance of nutrition. Beyond the assumption that the basic defect is concerned with faulty absorption in the upper intestinal tract, little can be said concerning exact etiologic factors. Pancreatic enzyme activity is well within normal limits. The pathologic picture is unknown since no postmortem studies have been performed on patients proved during life to have had idiopathic celiac disease. These patients respond readily to the well-known celiac diets.

Chronic Infection Causing the Celiac Syndrome.—Chronic diarrhea and important disturbances of nutrition may be caused by well known infections of the intestinal tract, such as typhoid and the various forms of dysentery, tuberculosis and parasitic diseases, such as amoebic dysentery. There is a large group of infants who have

chronic nutritional failure which may simulate the picture of idiopathic celiac disease and in these there is no evidence of infection within the intestinal tract. In these patients, however, careful search may reveal evidence of upper respiratory infection either in the lower respiratory tract or in the sinuses, nasopharynx, middle ears and mastoid antra or in the genito-urinary system. Pancreatic enzyme activity is normal. When the infection is cured the gastrointestinal disturbance frequently subsides without much difficulty.

Congenital Malformations.—Congenital malformations of the genito-urinary tract may be followed by secondary infection and the production of a chronic failure of nutrition. Congenital malformations of the heart with an impaired circulation may be responsible for malabsorption in the intestinal tract and consequent diarrhea and nutritional failure. A considerable amount of attention has been paid in recent years to the presence of congenital malformations of the mesenteric attachment. Minor degrees of faulty attachment of the intestinal tract we have found in approximately 5 per cent of all infants and children who come to autopsy, and in the majority of these no symptoms of digestive disturbance are associated with this finding. Recently in a small number of patients with the clinical picture of the celiac syndrome, with persistent or increasing abdominal distention and either constipation or diarrhea, abnormal positions of the cecum and the ascending colon and an abnormally long mesentery have been found by x-ray examination with the aid of barium. In several children, operations to correct this abnormality have been carried out, but startling improvement has not been the rule (personal communication from Dr. Robert E. Gross). Since this anomaly may occur so frequently without evidence of clinical disease or may be found incidentally in patients with real pancreatic disease, caution must be used before attributing the symptoms of the celiac syndrome in a given patient to anomalies of mesenteric attachment until complete studies have excluded the possibility of pancreatic disease. The normal level of pancreatic enzyme activity in patients with anomalies of mesenteric attachment differentiates this from pancreatic insufficiency.

Pancreatic disease leading to pancreatic insufficiency has been recognized in recent years as the

commonest cause of a severe form of the celiac syndrome. Studies in recent years have clarified the clinical picture and have been productive of precise methods of laboratory diagnosis and detailed characterizations of the pathologic changes.^{1,8}

There are two laboratory procedures of specific diagnostic value for the differentiation of pancreatic insufficiency from all other causes of the celiac syndrome. The first and the easier to perform consists in the analysis of pancreatic enzyme activity in the duodenal juice. If pancreatic insufficiency, no matter how produced, is responsible for the symptoms of the celiac syndrome in a given patient, pancreatic enzyme activity in the duodenal juice will be either absent or markedly reduced and there will be a hypochylia or achylia. Thus, rough differentiation may be made at once in patients with a chronic nutritional disturbance suggestive of the celiac syndrome between those with normal enzyme activity in the duodenal juice and those with pancreatic insufficiency. The second laboratory procedure of real aid is not performed as readily but is of real value. Examination of the stools as shown by Shohl and his colleagues will permit the demonstration of great increase in bulk, a high residue and an extremely high nitrogen content in patients with pancreatic insufficiency.¹⁶ There is only a moderate increase in fat.

Classification of Pancreatic Insufficiency.—If we assume that pancreatic insufficiency no matter how produced is responsible for the production of an insufficient amount of pancreatic juice with marked reduction of pancreatic enzyme activity in the duodenal drainage, two clinical pictures differing markedly from one another may be defined for the purpose of preliminary classification depending upon whether the pancreatic hypochylia or achylia was present before birth or was not produced until after birth. If pancreatic insufficiency was present before birth the baby will show evidence of high intestinal obstruction shortly after birth because of the inability of the bowel to pass along the abnormally tenacious meconium. If pancreatic hypochylia or achylia is not produced until any time after meconium has passed out of the intestinal tract the clinical picture will be celiac-like in type and will be characterized by chronic nutritional failure associated with wasting, foul, bulky feces, diarrhea and

stools with a high residue and a large nitrogen content. All these changes may be produced in the experimental animal by pancreatectomy or by

enter the duodenum and for eventual atrophy of the acinar portions of the pancreas and fibrosis of the organ. Duct obstruction may be caused

P A N C R E A T I C I N S U F F I C I E N C Y

Pancreatic Hypochylia and Marked Reduction in Pancreatic Enzyme Activity in Duodenal Drainage

....

Before Birth



MECONIUM ILEUS

(Intestinal Obstruction)

After Birth



CELIAC-LIKE NUTRITIONAL FAILURE

(Wasting; foul, bulky feces with high residue and large N content)

Caused by

Obstruction to Outflow of Pancreatic Juice

or

Failure of Formation or Liberation of Pancreatic Enzymes

diverting the pancreatic juice from the intestinal tract. These changes characteristic of pancreatic insufficiency may be brought about either because of obstruction to the outflow of pancreatic juice or because the pancreas is unable to form or to liberate pancreatic enzymes. On the basis of postmortem studies, the conditions responsible for pancreatic insufficiency may be divided logically into two main groups: those associated with local lesions where the entire disease process is limited to the pancreas and to adjacent structures, and those conditions which are responsible for a generalized disease involving many structures in the body including the pancreas. Let us consider first the local lesions.

From the physiological point of view the effects of a local lesion responsible for pancreatic insufficiency are limited to the consequences of reduction or absence of pancreatic enzyme activity in the duodenal content. Three groups of conditions may produce a local lesion responsible for pancreatic insufficiency. The first includes congenital malformations of the pancreatic ducts or of the pancreas itself. Congenital atresia or marked narrowing of the pancreatic ducts is responsible for failure of pancreatic secretions to

also by a regional malformation which includes annular pancreas and malposition of the pancreatic ducts. Most instances of annular pancreas do not cause pancreatic duct obstruction or pancreatic insufficiency but we have observed instances of this combination. Obstruction to the pancreatic ducts by gall stones, pancreatic stones, or by carcinoma of the head of the pancreas or of the duodenum, has been observed in adults to produce a picture of pancreatic insufficiency.^{3,4} Actual studies of the duodenal content in adults with carcinoma in the region of the head of the pancreas have demonstrated pancreatic achylia. Pancreatitis of any cause may be responsible for pancreatic insufficiency and the consequences will be limited to the effects produced by the local lesion.

The second group of conditions responsible for pancreatic insufficiency are generalized diseases involving many parts of the body. Involvement of the pancreas, although responsible frequently for the most important symptoms observed, is only one part of the disease process. Here the clinical picture includes the changes brought about by pancreatic hypochylia or achylia in addition to symptoms produced by the generalized disease.

CONDITIONS RESPONSIBLE FOR PANCREATIC INSUFFICIENCY

- I. Local Lesion - Restricted to Pancreas and Adjacent Structures
- II. Lesion of Pancreas - a Part of a Generalized Disease

- I. Local Lesion - (Effects are limited to consequences of reduction or absence of pancreatic enzyme activity)
 1. Congenital Malformations
 - (a) Atresia or Stenosis of Pancreatic Ducts
 - (b) Duct Obstruction Associated with Some Instances of Annular Pancreas
 2. Obstruction to Pancreatic Ducts by Gall Stones, Neoplasms, etc. (adults)
 3. Healed pancreatitis
- II. Lesion of Pancreas - a Part of a Generalized Disease
(Clinical Picture includes that caused by Local Lesion (I) plus symptoms produced by generalized disease)
 1. Vitamin A Deficiency (rare) - duct obstruction by keratinized debris
 2. Pancreatic Fibrosis caused by Congenital Lues (rare)
 3. Inspissation of material in many mucus-secreting structures (? mucinase deficiency) - Generalized MUCOVISCIDOSIS
 - (a) Pancreas - beginning with intra-acinar and small duct obstruction (commonest cause of pancreatic insufficiency in early life)
 - (b) Respiratory Tract - obstruction to trachea and bronchi by thick mucus followed by staphylococcus aureus pneumonia (almost constant accompaniment of pancreatic lesion)
 - (c) Liver - Focal Obstructive Biliary Cirrhosis (bile capillaries obstructed by inspissated mucoprotein) - rare
 - (d) Glands - Salivary, gastro-intestinal, gall bladder, etc. (dilated and obstructed by viscid mucus)

The first condition, vitamin A deficiency, is a rare cause of duct obstruction leading to pancreatic insufficiency. The metaplasia of epithelium lining the ducts produced by vitamin A deficiency may be responsible for the piling up of masses of keratinized epithelium in the lumens of the ducts leading to obstruction and eventual atrophy and fibrosis of the organ. In such patients similar changes may be found in the renal pelves, in the trachea, the bronchi, the salivary glands, and nares. Although vitamin A deficiency may be a complication of any disease responsible for pancreatic insufficiency it is only rarely the cause of pancreatic insufficiency itself. A second and also rare cause of a generalized disease responsible for pancreatic insufficiency is congenital lues. Fibrosis of the liver, spleen and pancreas occurs as an almost constant triad of pathologic changes in this disease. Luetic fibrosis of the pancreas occasionally may be so marked as to interfere to an important extent with the outflow of pancreatic juice with the production of atrophy of the acinar portions of the gland and pancreatic insufficiency.

The third generalized disease responsible also for pancreatic insufficiency is one which has been called variously cystic fibrosis of the pancreas, pancreatic fibrosis, pancreatic steatorrhea, and a number of other equally unsatisfactory names. Our recent demonstration that this systemic disease which accounts for the majority of all infants and children with pancreatic insufficiency is caused by an alteration in the physical character, leading to inspissation of materials in many mucous-secreting structures in the body has furnished an explanation for the pathologic changes in the upper respiratory tract, the lungs, the liver, the pancreas and the salivary glands.⁷ The symptoms referable to the upper respiratory tract which may be so striking as to obscure the chronic nutritional failure produced by the pancreatic insufficiency have been ascribed to chronic pulmonary infections. It appears likely that the initial disturbance is produced by inspissation of mucus in the mucous glands of the trachea and bronchi which fills the upper respiratory tract with thick tenacious mucus capable of causing partial obstruction to the outflow of air from the lungs. Long continued partial obstruction accounts for hyperexpansion and atelectasis found characteristically on physical and x-ray examination. Secondary infection by the ubiquitous staphylococcus

aureus is responsible for the relatively low-grade pulmonary inflammatory process found in all patients who have had the disease for more than a few weeks. Despite the presence of infection, however, the most important damage to the respiratory tract is the physical interference with air exchange produced by thick mucus which actually may asphyxiate the patient. Occasionally a similar alteration in the physical properties of mucoprotein elaborated by bile duct epithelium may be responsible for a diffuse severe obstructive cirrhosis. The pancreatic insufficiency in this generalized disease may produce a clinical picture almost indistinguishable from idiopathic celiac disease, or the symptoms of upper respiratory obstruction and pulmonary disease may be so striking as to obscure or to place in secondary importance the chronic nutritional failure occasioned by the pancreatic insufficiency. The varied clinical pictures produced by the generalized alteration in the physical character of secretions of mucous glands demands a designation more inclusive than *pancreatic fibrosis* or *cystic fibrosis* which describes only one feature of the disease. Until the etiologic factors are defined and for the purposes of present convenience only a purely descriptive term suggested by the physical character of the material produced by mucous glands in this disease may be employed—*muco-viscidosis*. This has been chosen after careful consideration of many descriptive terms because it calls attention to a striking change which appears to be the common denominator leading to pathologic changes in all parts of the body affected in this disease. It is proposed for temporary convenience only and should be dropped as soon as a diagnostic term based on etiology can be found.

The recent demonstration that the majority of patients with pancreatic obstruction in infancy and childhood suffer from a systemic disease of which pancreatic involvement is but one part, has led to the assumption that in meconium ileus, too, the pancreatic disease is but part of a generalized process involving many glandular structures in the body. Because of this the initial wave of enthusiasm for the suggested method of treatment has been followed by a pessimistic outlook since it has been assumed that if the patient recovers from his immediate obstruction he will survive only to die some time later of respiratory disease or involvement of some other part of the body. This pessimism is not entirely jus-

tifiable. In meconium ileus the cause may be a local congenital malformation of the pancreatic ducts and the entire disease may be limited, therefore, to the pancreas itself.⁹ In that case simple pancreatic substitution therapy and replacement of lost nitrogen by means of new amino acid preparations should be sufficient to maintain life satisfactorily if the initial intestinal obstruction is relieved. Then, too, when the pancreatic lesion is part of a generalized disease it is conceivable that the generalized involvement may not include vital areas of the body. It appears well worth while to continue vigorous attempts to treat and study this disease along the lines suggested by pathologic and physiologic observations.

What has been said in regard to meconium ileus applies even more to the chronic failure of nutrition (the celiac syndrome) caused by pancreatic insufficiency. If the cause of the pancreatic insufficiency is a local disease of the pancreas the problem of treatment is not complex and the prognosis should be good. Pancreatic substitution therapy in the form of minute granules, each of which is enteric coated, in amounts 2 to 5 gms. daily should compensate for the pancreatic insufficiency. The loss of nitrogen in the stools which may cease after adequate pancreatic substitution therapy has been established may be corrected by the administration of casein hydrolysate.¹⁰ Vitamin supplementation of the diet with emphasis on preparations of vitamins A, D, C and the B complex have proved their value.² Improvement of the muscle tone in the intestinal tract by the parenteral administration of prostigmine has been recommended to enhance nutrition in general and absorption of vitamin A in particular.¹⁰ On such a regime the pancreatic insufficiency should be corrected and the consequences of the chronic failure of nutrition should soon disappear. In this connection, the experience of Beazell, Schmidt and Ivy with adults suffering from pancreatic insufficiency may be mentioned.³ They state that they have never known failure to correct pancreatic achylia either in man or in the experimental animal if adequate pancreatic substitution therapy were employed.

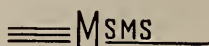
Quite a different problem is found when the pancreatic insufficiency in children is a part of the systemic disease which we have called for temporary convenience *muco-viscidosis*. The treatment of the pancreatic insufficiency should

be the same as in the case of the localized pancreatic disease. In addition, however, the disease processes in the lungs, the upper respiratory tract and even the liver and the salivary glands which may be present, alter the problem. In our experience no cure has been observed so far in patients with this systemic disease. Death is produced usually by upper respiratory and pulmonary obstruction and infection. The use of penicillin and the various sulfonamide preparations has not proved curative although real improvement in the upper respiratory symptoms have been produced.⁵ If it is proved, therefore, that in a given patient the pancreatic insufficiency is but a part of a generalized disease the prognosis is poor particularly if the upper respiratory tract is involved. What is needed in addition to the treatment for the pancreatic insufficiency and the symptomatic treatment for the respiratory aspects of the disease is a method of liquefying or thinning the physically altered, extremely viscid mucus in the various mucous glands of the body. The tremendous power of regeneration of the pancreas provides a note of cheer, and indicates that the pancreatic disease is reversible, if a suitable treatment can be found. The experimental production in animals of histologic changes characteristic of this generalized disease by the use of parasympathomimetic drugs (pilocarpine, mecholyl) provides at least a logical approach in the search for a badly needed remedial agent.⁶ When this is achieved, the pancreatic insufficiency associated with this systemic disease should be corrected more directly than by the substitution and replacement therapy advocated today, and an extremely important and highly fatal digestive disturbance in early life will cease to be a problem.

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Michigan Rapid Treatment Center

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Medical Officer in Charge Michigan Rapid Treatment Center, Ann Arbor; Surgeon (R), U. S. Public Health Service

■ THE Michigan Rapid Treatment Center is a hospital designed to treat patients with venereal disease in the infectious stage, and is operated by the Michigan Department of Health in co-operation with the United States Public Health Service.

Any individual, regardless of race, sex, or color, may be accepted *provided he is unable to pay for treatment from a private physician or hospital, or is in urgent need of quarantine*. No charge is made for the treatment either to the patient or to his community. The recommendation of the referring agency concerning the patient's inability to pay for private treatment is accepted by the Center unless evidence to the contrary is obtained in the social history taken on admission. In this event, the hospital communicates immediately with the referring physician or clinic and arrangements are made to send the patient to the private physician or institution chosen by them after such consultation.

Patients with syphilis generally require two weeks for complete treatment; those with gonorrhea, one week.

Any health department or physician in private practice may refer a patient to the Michigan Rapid Treatment Center, but it is generally more satisfactory if the physician will act through his

local Health Officer. To refer a patient to the Center, a bed reservation must be made either by calling Ann Arbor 2-6541, or by wiring or writing the Michigan Rapid Treatment Center, 1135 East Catherine Street, Ann Arbor, Michigan. Communications of this nature may be directed to Dr. Nelson W. Ryan, Medical Officer in Charge.

The cost of transporting patients to and from the Center is borne by the referring agency or the patient himself. When such funds are not available, the Michigan Rapid Treatment Center will pay the cost of transportation if accomplished by bus, rail, or both, at the regular rates less tax.

Tax exemption certificates should be presented to the carrier and receipt obtained for travel. The receipt obtained is to be presented with a signed State Travel Voucher, to the Michigan Rapid Treatment Center to enable the referring agency to obtain the refund. When it is not possible or advisable to send patients by public transportation facilities, but instead an automobile is used, reimbursement is as follows: \$0.06 per mile or \$3.00 per patient whichever is less. In no case will the patient be reimbursed for travel.

Any physician or agency referring a patient to the Michigan Rapid Treatment Center should give to the individual a letter having the following information:

1. Name of patient
2. Address
3. Diagnosis
4. Result of *all* laboratory procedures performed, such as serologic tests, darkfield examinations, gonorrheal spreads and cultures, spinal fluid examinations and any other diagnostic tests done, together with dates of their performance.
5. Accurate record of previous treatment with dates and dosage.

Forms for recording this information may be obtained by writing to the Center.

Treatment of Syphilis

Types of Syphilis Treated.—

1. Primary and Secondary Syphilis.
2. Early Latent Syphilis (asymptomatic syphilis of four years' duration or less. This group is composed of those patients who show only a positive serologic reaction. They present no physical signs of syphilis and their spinal fluids are normal).
3. Early Asymptomatic Neurosyphilis (four years' duration or less).

The purposes, objectives and outlines of treatment here mentioned were presented to the Venereal Disease Control Committee of the Michigan State Medical Society and were approved.

No patient is admitted for intensive therapy who has had more than ten previous arsenical injections, and the majority of these injections should have been administered at least six weeks before admission to the Center. However, chemotherapeutic control of a case of infectious syphilis with one or two arsenical injections is permissible and may be advisable when there is to be a delay in the patient reporting to the Center.

Routine Preparation and Study of the Patient for Treatment at the Michigan Rapid Treatment Center.—

1. A complete history is taken. The names of contacts obtained from this history are reported to the health department in the community where the contacts live.
2. A complete physical examination is done.
3. Serologic reactions for syphilis are obtained. One specimen of blood is sent to the Michigan State Laboratory and one to Dr. Kahn's Control Laboratory at the University of Michigan. Quantitative tests are performed on these specimens by both laboratories.
4. A spinal fluid examination is done, which includes quantitative protein determination, cell count, colloidal gold, globulin determination, and quantitative spinal fluid titer.
5. A darkfield examination of any lesions present is done.
6. Complete blood count and urine examination are done routinely.
7. Liver and renal function tests are done when indicated.

Types of Anti-Syphilitic Treatment Used at the Michigan Rapid Treatment Center

1. Combination Penicillin, Mapharsen, Bismuth Schedule.—This consists of the administration of:

- (a) 10,000 units of penicillin intramuscularly every three hours for sixty injections, totalling 600,000 Oxford units, plus
- (b) 1 mgm. Mapharsen per kilogram of body weight up to 60 mgm. daily for eight days, given intravenously concurrently with the penicillin, plus
- (c) 200 mgm. of bismuth subsalicylate intramuscularly on the first, fifth, and eighth days of the treatment schedule.

Following dismissal from the Michigan Rapid Treatment Center, nine similar injections of bismuth are given at weekly intervals by the referring agency or physician.

This schedule of treatment has only recently been adopted by the Michigan Rapid Treatment Center. It is hoped this plan may show whether any synergism may exist between penicillin, arsenic, and bismuth. Such a schedule also permits a greater number of patients to be treated with a given amount of penicillin. In addition, the patient receives a smaller dose of a potentially dangerous arsenical than with the eight-day schedule. At the present time a majority of our patients are being treated by this plan. Any patient who has syphilis of less than four years' duration may be treated at the Center with this method.

All patients with syphilis are isolated and confined to bed until the end of the second day of treatment. Thereafter they are ambulatory.

2. Penicillin Therapy.—The present schedule consists of the administration of 1,600,000 Oxford units of penicillin over a period of ten days. It is given in doses of 20,000 Oxford units intramuscularly every three hours for eighty injections. Each dose is dissolved in 2 to 4 c.c. of distilled water.

During the first twenty-four hours a Herxheimer reaction is frequently observed. The only other reactions to the drug encountered, have been the occurrence of a generalized urticaria early in the course of treatment, and discomfort at the site of injections. Both are uncommon. No reactions have been severe enough to interfere with treatment.

No anti-syphilitic treatment should be given penicillin-treated patients after discharge from the Center.

3. Eight-Day Slow Drip Massive Arsenotherapy.—Until recently this has been our schedule of choice, but at the present time it is used only in selected cases, and when penicillin is not available. The method consists of the administration of 1080 mgm. of Mapharsen by the slow continuous intravenous drip method over a period of eight days, in the following schedule:

1st day 240 mgm. Mapharsen in 2000c.c. 5% glucose in distilled water.					
2nd day 120 mgm. in distilled water.	"	"	1000	"	" glucose
3rd day 120 mgm. in distilled water.	"	"	1000	"	" glucose
4th day 120 mgm. in distilled water.	"	"	1000	"	" glucose
5th day 120 mgm. in distilled water.	"	"	1000	"	" glucose
6th day 120 mgm. in distilled water.	"	"	1000	"	" glucose
7th day 120 mgm. in distilled water.	"	"	1000	"	" glucose
8th day 120 mgm. in distilled water.	"	"	1000	"	" glucose

The intravenous apparatus is regulated to deliver approximately 30 drops per minute. This allows 2000 c.c. of the Mapharsen glucose mixture to be administered in approximately sixteen hours. When 1000 c.c. of this mixture is given administration takes about one-half this time.

The reactions most frequently encountered in this method of therapy are:

- Moderate nausea and vomiting during the first twenty-four hours of treatment.
- A Herxheimer reaction during the first twenty-four hours, manifest generally by an intensification of all signs and symptoms already present, plus an elevation of temperature.
- The occurrence of an erythematous skin reaction, known as the phenomenon of Milian, or erythema of the ninth day. It occurs in a small portion of cases on about the seventh day of treatment.

These reactions are usually mild, and very rarely interfere with treatment.

Severe or fatal reactions to intensive arsenotherapy are fairly uncommon. Hemorrhagic encephalitis, peripheral neuritis, exfoliative dermatitis and blood dyscrasias may occur. Every precaution is taken to avoid these phenomena.

Treatment for Gonorrhea

Two types of gonorrhea patients are accepted for treatment at the Michigan Rapid Treatment Center:

- The patient who has failed to respond to sulfonamide therapy (at least 20 grams).
- The patient who cannot be treated by his local community, either because he is unco-operative, or because the community is unable to provide the necessary therapy.

Before treatment is administered a history is taken, a complete physical examination is made, and the diagnosis of gonorrhea is confirmed, if possible by the obtaining of positive spreads and cultures. If such confirmation cannot be obtained, the patient may be treated on a basis of clinical findings or epidemiologic evidence.

The treatment for gonorrhea administered by the Michigan Rapid Treatment Center consists of 150,000 Oxford units of penicillin administered intramuscularly, in individual doses of 20,000 units every three hours for seven injections and an eighth injection of 10,000 units. The entire dose of penicillin is thus administered in a period of twenty-one hours. Two negative spreads and cultures taken on consecutive days following treatment, constitute the criterion for cure. (See further observation recommended under Follow-up Plan.)

Response to Treatment

With all methods of therapy previously discussed, there is rapid clinical improvement. Most signs of primary and secondary syphilis have disappeared by the end of the treatment schedule.

The serologic response is somewhat slower. The fall in titer is related to the age of the disease. The shorter the duration of the infection, the quicker the return to sero-negativity. Generally, four to six months are necessary for this, but occasionally a much longer period is required. Serologic progress can be satisfactorily determined only by quantitative tests as recommended under the Follow-up Plan, and physicians are urged to secure such tests rather than standard ones in appraising serologic response. The serologic titer is often higher for a short time following treatment than before, due to a serologic Herxheimer reaction or lag phenomenon. Relapses, of both clinical and serologic types, do occur, and should be considered possible in all cases of syphilis for at least one year after treatment is concluded.

The results of eight-day Slow Drip Massive Arsenotherapy compare favorably with routine eighteen months' treatment. Many investigators feel that they are considerably better.

The relapse rate following the use of penicillin, alone as well as in combination with arsenic and bismuth, has not been definitely established at present, due to the short time these schedules have been employed. Early observations, however, seem quite encouraging.

Follow-up Plan

The Michigan Rapid Treatment Center co-operates with the referring agency or physician in the follow-up of patients treated for syphilis. When a patient is dismissed from the Michigan Rapid Treatment Center, he is given detailed instructions concerning his follow-up treatment and observation. The referring agency meanwhile is notified of his diagnosis, treatment and dismissal date, together with the plan for follow-up. Following dismissal, the Michigan Rapid Treatment Center notifies the patient by mail when each serologic and clinical check-up is due. These examinations are performed by his physician or clinic. At each such check-up a 5 c.c. specimen of blood is drawn, which is sent to the Michigan Department of Health Laboratory. A quantitative serologic test is performed and reports of this test are mailed to both the physician or clinic, and to the Michigan Rapid Treatment Center. In the event of a suspected relapse, the physician or clinic is earnestly requested not to administer further treatment to the patient, until discussing the matter with the Michigan Rapid Treatment Center.

Patients who have gonorrhea are dismissed from the Michigan Rapid Treatment Center as presumably cured, and no plan of follow-up is provided. The referring physician or clinic is notified of the patient's diagnosis, treatment and dismissal date. It is suggested that follow-up examinations be made at regular intervals.

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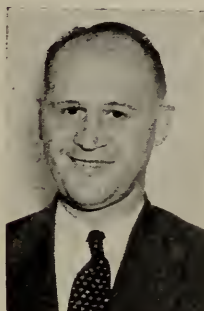
In conclusion, the staff of the Michigan Rapid Treatment Center wishes to take this opportunity to express its appreciation to all of those physicians, nurses, case workers and others, who have demonstrated such keen interest in the work. We are constantly striving to increase the quantity and quality of assistance given the physicians of Michigan in their fight against venereal disease, and will appreciate any suggestions to further this purpose. Persons who are interested in venereal disease or its associated problems are cordially invited to visit the Center.

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The economic and social handicaps of persons with impaired hearing are so great they should not be increased with the label "deaf." Prophylaxis and hearing aids do wonders. Their use should be encouraged, and considered the same as glasses for impaired sight. Those who use eye glasses are not labeled "blind."

What We Have Learned About Aviation Medicine

By Charles J. Clark, M.D., and
Harry Britton, M.D.
Willow Run, Michigan



CHARLES J. CLARK

Flight Surgeon and Assistant Flight Surgeon, Willow Run, Michigan.

The subject of Aviation Medicine should have a strong appeal, not only to those specifically interested in this subject as a specialty but also to regular medical students and to those engaged in the program of general medicine. At the present time, between two and three millions of our population take to the air each year and the time has come when no physician can remain totally ignorant of the effect of flying on the human organism, and at the same time be prepared to intelligently advise, treat, or examine those interested in flying whether it be as pilot or as a passenger. In certain circumstances aerial environment may be more deadly than any plague and every properly-trained physician should possess a general knowledge of aviation medicine just as he possesses a general knowledge of other special fields of medicine. The advances in aviation medicine have been so rapid in recent years that it is almost impossible not to overlook valuable contemporary work. It should be borne constantly in mind that aviation medicine, which has heretofore been regarded as a rather disconnected collection of parts of several other medical specialties, should now be presented as a distinct and special entity in itself.

■ THE subject of Aviation Medicine is not new.

In fact, it is as old as aviation itself, and it is impossible to study the history of one without necessarily involving the history of the other. The desire to fly has persisted in man's mind since the beginning of time. One only has to look at ancient mythology and he will find characters portrayed with wings, and it is probable that the custom of depicting angels with wings is based on the ancient conception of flight as being beyond the attributes of mortal man.

Contrary to most people's belief, aviation itself is not new, and as early as the thirteenth century we have the works of Roger Bacon and later Leonardo da Vinci, both of whom wrote about and designed aircraft, the basic principles of which are still sound today. Man's first bid for the control of the air was in the nature of the

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balloon and we owe it to the French for being the initial experimenters in this new field. In 1782, the Montgolfier brothers constructed a small light silk balloon and filled it with smoke. It rose to the ceiling of their room, and encouraged by this they constructed larger balloons made of linen lined with paper, and sent their first passengers aloft in September of 1783. These first passengers were respectively, in order of their ascent, a chicken, a duck, and a sheep. During the next one hundred and fifty years the balloon was perfected, and hydrogen replaced the use of smoke. Gradually the balloon was improved and eventually the dirigible and the zeppelin were developed from it. This development did not occur without mishaps, however, and two of them were destined to have an important influence on aviation medicine. In 1862, Glaisher and Coxwell made a balloon ascent to an altitude of approximately 29,000 ft. during which the former noticed a series of strange symptoms marked by a loss of visual acuity and hearing, paralysis of the legs and arms, and finally by unconsciousness. And at the same time his companion, Coxwell, also found that his arms were paralyzed but had the presence of mind to seize the valve rope with his teeth and start the balloon downward. These facts came to the attention of Paul Bert, a brilliant French physiologist, who began a study of the effects of increased and decreased barometric pressures.

During these studies Bert had as one of his subjects, Tissandier, a meteorologist, who with two others, Croce and Sivel, were planning a high altitude balloon flight which was made in 1875 and ended in tragic disaster. The balloon ascended to 28,820 feet and then descended of its own accord. Tissandier recovered but his companions were dead. Deeply touched by this unfortunate accident and Tissandier's graphic description, Bert continued with renewed vigor the effects of decreased barometric pressures and three years later published his famous "La Pression Barometrique." The number and accuracy of Bert's experiments and deductions considering the facilities with which he had to work are astounding, and he was not only the first to prove that the principal effect of high altitude was due to the decreased partial pressure of oxygen, but he also carried out innumerable researches including carbon dioxide in the lungs and blood, and probed deeply into the question

of respiration and blood gases under decreased barometric pressures. As a result of Bert's work, we cannot help but confer upon him the honor of being the father of Aviation Medicine as well as being the first Flight Surgeon.

The developments of the balloon, however, did not satisfy man's desire to fly like a bird. He wanted wings and speed, and the lighter-than-air balloon satisfied neither of these desires. England and Germany began experimenting with toy helicopters but it remained for the Wright brothers and their famous flight in 1903 at Kitty Hawk, North Carolina, to begin the vast aeronautic industry as we know it today.

Until this point, with the exception of the work of Paul Bert, medicine seems not to have had any part in the development of aviation or any concern for those who were engaged in it. Even as late as 1910 there were only a few scattered articles in the medical literature on aviation medicine and those were mostly of a speculative nature. During the first world war, aviation medicine came into its own, and it was Germany who pointed the way. At the outbreak of World War I, the Germans were more advanced in their concepts in this field than those in any of the other countries. By the end of 1917, however, all of the Allies and the Germans had medical departments which were integral parts of their air service and in each was included the best specialists in their respective countries. In the United States during this early period, Aviation Medicine lagged slightly behind that in Europe due to two principal causes. First, although the airplane was an American invention, no great amount of interest was manifested in it here before the World War, and the Wright brothers took their invention to Europe where flying immediately became popular. Secondly, the United States did not enter the war until three years after most of the other combatants, and military aviation in this country did not begin to develop on a large scale until 1917, and the term Flight Surgeon was first coined in March, 1918.

Man adjusts himself to his surroundings to a remarkable degree. The human body constantly makes adjustments for changes in external temperature, for varying amounts of physical activity, for motion in space, for postural changes in relation to gravity, for changing energy requirements, and adjustments against the inroads of toxic agents and disease. Changes in respiration, in the

activity of the sweat glands, in the function of the kidneys, in the ingestion of food, or in the desire for rest or physical activity, all tend to maintain the internal environment of the body within very narrow limits of fluctuation.

In aviation the demands upon the compensatory mechanisms of the body are numerous and of considerable magnitude. The environmental changes of greatest physiologic significance involved in flight are: (1) marked changes in barometric pressure, (2) considerable variation in temperature, (3) movement at high speed in three dimensions, and (4) change reflected in the mechanical characteristics of the flying machine itself as an abode or medium,

Aeronautical and mechanical science has advanced rapidly in the past decade, resulting in the development of highly maneuverable airplanes that can cruise at 400 miles an hour, climb a mile a minute, and operate effectively at 30,000 feet or higher. It is obvious that man cannot operate these machines at full capacity without physical aids such as an artificial supply of oxygen and pressurized equipment for use at extreme altitudes. Sharp turns or pullouts from dives at high speed cause centrifugal effects, many times the normal effect of gravity, leading to unconsciousness if the effects are prolonged.

Man, then, as a flying creature must overcome the handicaps imposed by nature on an organism "designed" for terrestrial life. The necessary aids are largely mechanical. It behooves flyers to understand the mechanical characteristics of their machines but, likewise, they must know the functioning of the human body under the special conditions imposed by flight. In particular, the limiting factors in adjustment of the human body to flight must be appreciated. The extent to which these limiting factors are alleviated by available equipment must be clearly understood. Indifference, ignorance, and carelessness can nullify the foresight, ingenuity, and effort involved in the supplying of efficient equipment. The ultimate result is failure of missions and unfortunate experiences by personnel.

The very intimate relationship between certain basic principles of Aviation Medicine and success in the design, operation, or piloting of airplanes makes it highly desirable that those in the Aviation Industry have available general information on Aviation Medicine. Heretofore, Aviation Medicine has been generally regarded as a

rather disconnected collection of parts of several other medical specialties but the subject should be presented as a distinct and separate entity within itself and pathological conditions peculiar to Aviation Medicine, as definite clinical entities rather than as isolated experimental findings. It should have a strong appeal to regular medical students and to those engaged in the general practice of medicine as well as those specifically interested as a specialty. At the present time over two millions of our population take to the air each year and the time has come when no physician can remain totally ignorant of the effect of flight on the human organism and at the same time be prepared to intelligently advise, treat, or examine those interested in flying whether it be as a pilot or passenger. Every properly trained physician should possess a general knowledge of aviation medicine just as he possesses a general knowledge of other special fields of medicine. The art of Aviation Medicine cannot be described by writing or by word of mouth. It is an abstract something which is inherent in an individual and is intimately associated with personality. The Flight Surgeon must have a solid foundation of general medical knowledge crowned by an adequate fund of special knowledge. This lends dignity and poise to the flight surgeon which makes his opinions and judgments respected. Secondly it inspires confidence in flying personnel and removes any question of doubt as to the reliability of findings in routine examinations or in case of illness. The Flight Surgeon must be free from prejudice and subjugate his personal feelings and desires in order that there shall be no hint of partiality or favoritism shown. He must be reasonable in propounding his opinions and advice, and be prepared to defend them with facts and logic. Finally, he must have a depth of human understanding which will naturally cause those for whom he is responsible to turn to him for guidance and advice in time of stress or need.

The duties of a Flight Surgeon may be divided into four general categories. First and foremost, he must be a physician and must never forget that he is a doctor first and a Flight Surgeon only secondarily. He should be fully qualified not only to diagnose and treat the general run of ailments but he should be qualified especially to treat traumatic cases. The second general type of duty required of a Flight Surgeon involves the selection of candidates for flying training and his exami-

nations must be accurate and thorough. In this respect it has been found that the greatest weakness in the examination for flying is not the standards as set up by regulations, but the manner in which the examination is conducted. Instances of total blindness in one eye and frank psychoses have been known to escape the notice of examiners and this could have occurred only from gross neglect or carelessness.

The principal duty of the Flight Surgeon is the "care of the flyer." The fact that airplane pilots required a special medical supervision first became apparent in 1917 and was a direct cause of the Flight Surgeon being created. It was soon evident that pilots in the various air services were being subjected to stresses and deleterious environmental influences which were not properly understood or fully appreciated. It was also concluded that flight personnel were reluctant to seek medical attention for fear of being considered lacking in courage. Immediately upon assigning special medical care to the flight service it was noted that there was a decided success in raising the morale and efficiency of the flying personnel, and at the same time marked reduction in accident rates.

The fourth duty of the Flight Surgeon is to continually investigate the effects of flight and seek remedies for those environmental conditions which may have an adverse influence. The increase in size, weight, speed, maneuverability and technical complications of aircraft each year results in new problems in Aviation Medicine. Aviation Medicine is a constructive living science. It can be kept so only by those who are fortunate enough to have the opportunity to advance its knowledge. There is no Flight Surgeon today worthy of the name who could not, if he would, contribute something new and worth while to the literature on Aviation Medicine.

There is probably no other specialty in medicine at the present time which has so much to offer to the properly qualified physician. Aviation Medicine in civil life is as yet almost devoid of well-trained full-time men who are prepared to devote their life to this work. Certainly no other branch of medicine can be as fascinating or offer a broader field of endeavor, for no longer is Aviation Medicine restricted to the selection of candidates for flying training, or to the re-examination of graduate pilots, but includes hygiene, sanitation, epidemiology, aero biology, physiology,

psychology, cardiology, ophthalmology, otology and pure research insofar as these sciences apply to flight. Nor can we think only of the pilot, but in addition must consider other members of the crew required on large modern aircraft and of the comfort, health, and safety of the traveling public, thousands of whom are in the air every hour of the day and night and whose welfare is a responsibility of Aviation Medicine.

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Sulfonamide Resistant Gonorrhea

By Captain Arthur W. Frisch, MC, AUS
Battle Creek, Michigan



The term "sulfonamide-resistant" gonorrhea has acquired a clinical rather than a bacteriological connotation. Failure of patients to respond to treatment may be due to (1) inadequate dosage; (2) obstruction to effective drainage of pus in one or more foci within the glandular elements of the genito-urinary tract; (3) failure of the drugs to penetrate the infected tissue; or, (4) the development of "fastness" to one or more of the sulfonamides. For the above reasons a simple method of determining bacteriologic sensitivity was devised in which urethral exudates were cultured on media containing sulfonamides and penicillin and the growth of gonococci was compared with a control plate without drugs.

Among clinically-resistant cases of male gonorrhea only 37 per cent were found to harbor organisms which had acquired tolerance for sulfathiazole. On the other hand all of the bacteriologically-resistant culture were susceptible to the action of penicillin. The management of these cases is discussed.

■ IN the past decade significant advances have been made in the diagnosis and treatment of gonorrhea. From a practical point of view these studies have now made it possible for practitioners and specialists alike to accurately diagnose and to subsequently declare cured those patients who have contracted this important form of venereal disease. Formerly the stained smear

From the Laboratory Service, Percy Jones General Hospital, Battle Creek, Michigan.

Read before the Fourth Annual Postgraduate Conference on War Medicine, the Seventy-Ninth Annual Session of the Michigan State Medical Society, Grand Rapids, Michigan, September 27, 1944.

had been almost entirely relied upon for diagnostic purposes. At present nearly all strains of gonococci may be grown and identified with relative ease both in hospitals and in private laboratories. This has been accomplished through the use of special preparations of proteoses and a recently described yeast extract which is incorporated into heated blood agar; by recognition of the fact that increased carbon dioxide tension facilitates growth; and by the utilization of the oxidase reaction as a means of isolating individual colonies of gonococci from mixed urethral and cervical cultures. We can look forward to further improvements in the future, especially along the lines of newer methods of preserving gonococci in a viable state so that cultures may be shipped long distances for identification purposes. The substitution of cultural methods for diagnostic smears has been of particular importance in female gonorrhea where the difficulties of diagnosis and of establishing criteria for cure are well known. Since the female is often the silent reservoir for this disease the advantages of culture cannot be over-emphasized.

Startling advances in the treatment of gonorrhea have been made possible by the introduction of the sulfonamide drugs and more recently by penicillin. Statistics from various sources are somewhat conflicting but in general approximately 80 per cent of new cases respond favorably to adequate courses of sulfadiazine or sulfathiazole. For example in a recent report by Campbell and Carpenter² involving 2,100 male patients, the over-all recovery rate was 81.6 per cent with a single course (20 gm.) of sulfathiazole. An additional 9.2 per cent were cured with a second course of the same drug. Unfortunately therapy is not curative in ten to twenty per cent of cases usually classed as "sulfonamide resistant," a term which has assumed a clinical rather than a bacteriological connotation. Actually this group represents a therapeutic challenge to the individual doctor who must now exert a maximum degree of ingenuity to establish reasons why a favorable response was not obtained. Factors which may be responsible are inadequate dosage^{3,4,6}, obstruction to effective drainage of pus in one or more small foci within the glandular elements of the genito-urinary tract⁴, inadequate penetration of drugs into infected tissues⁶, and

finally, the development of resistance to sulfonamides by the gonococci. Time does not permit a complete discussion of the above factors but if ineffective blood levels result from poor absorption, or if stricture sites do not receive drug because of inadequate circulation, or if small abscesses in the prostate interfere with sulfonamide action as is the case of all localized suppurations, then the correction of these conditions becomes essential in order to effect a cure of the disease. When the above causes for therapeutic failure have been eliminated, the possibility of "drug resistance" should then be entertained.

Numerous procedures have been developed for determining whether gonococci are sensitive or resistant to the sulfonamide drugs. More complicated methods such as the use of whole blood for growth-inhibiting effects³ and even the infected chick embryo¹ have not been practical for ordinary purposes. Techniques involving cultures on plates with and without sulfonamide drugs have proved to be most useful for correlating the clinical with the laboratory results. For the past year we have been culturing gonococci in chocolate agar plates containing 5 mg. per cent of sulfadiazine and sulfathiazole in an effort to determine the true incidence of drug-resistant strains of gonococci among cases treated unsuccessfully with the sulfonamide drugs. The following method was used: Proteose No. 3 (Difco) chocolate agar plates containing 5 mg. per cent of sodium sulfathiazole or sulfadiazine were prepared by adding the appropriate amount of drug to 10 c.c. of medium. The urethral cultures were taken with sterile swabs which were immersed in 1 c.c. of brain-heart infusion broth, shaken thoroughly, and streaked on both the control and drug-containing plates. The cultures were incubated under carbon-dioxide tension for forty-eight hours, sprayed with p-aminodimethylaniline-monohydrochloride, and the amount of growth on all three plates was compared. Gram stains were made from representative oxidase-positive colonies. The results were cleancut and little difficulty was encountered in differentiating *Neisseriae* from other organisms. Frequently the control and drug plates showed equal numbers of gonococci but the individual colonies appeared to be stimulated by the presence of the drugs so that they were distinctly larger than

the control. The presence on the plates of contaminating organisms did not seem to influence the final result.

A control group of 81 "acute" cases of gonorrhea were first studied in order to test the efficiency of the method. The following results were obtained. The growth of 98 per cent of the gonococci was completely inhibited by plates containing 5 mg. per cent of the two drugs. One culture grew partially and another maximally in the presence of sulfonamides. Both of the above cases proved to be resistant to treatment. Ten additional cases were classified as being clinically resistant but eight of these were cured within one month by additional courses.

A second group of 100 so-called clinically-resistant cases of gonorrhea admitted to the Percy Jones General Hospital were studied by the same method. All patients included had been so classified prior to admission; they had received two or more courses of sulfonamide therapy and had been infected for two or more months. The bacteriologic examination of cultures revealed the following: In contrast to the acute cases it was found that 58 per cent of the cultures grew to some degree on plates containing 5 mg. per cent of sulfadiazine and 37 per cent of the cultures behaved similarly toward sulfathiazole. It would appear that a relatively high degree of drug tolerance does not occur as frequently as one might anticipate among clinically-resistant cases of gonorrhea since only 35 per cent and 22 per cent of the respective cultures grow maximally in the concentration of the two sulfonamides used. It was surprising to find that the growth of 42 per cent and 63 per cent of the cultures was completely inhibited by 5 mg. per cent of sulfadiazine and sulfathiazole respectively, concentrations easily within the therapeutic range.

Comparison of the action of the two drugs on gonococci revealed that resistance developed more readily to sulfadiazine than to sulfathiazole. In fact, among the group of thirty-five cultures which were maximally resistant to sulfadiazine, growth of ten was completely inhibited by sulfathiazole.

The following program is suggested and is readily applicable to gonorrhea in the male. Urethral exudates from suspected cases should be cultured on standard proteose No. 3 chocolate agar and on two additional plates in which 0.5 mg. per cent and 5.0 mg. per cent of sulfathiazole

have been incorporated. This procedure would permit a division of cases into three major groups: (1) no growth of gonococci in either concentration of drug; (2) partial or maximal growth in 0.5 mg. per cent sulfathiazole but none in 5.0 mg. per cent; and (3) partial or maximal growth in 5.0 mg. per cent of sulfathiazole. Patients in group 1 should respond promptly to routine sulfonamide therapy as predicted by the results of Goodale, Gould, Schwab and Winter.⁵ Those in group 2 might require additional courses with larger doses of drug and eradication of encapsulated foci before a cure is effected. The cases classed in group 3 should not be subjected to the hazards of additional sulfonamides but should be immediately considered as candidates for fever or penicillin therapy. Repeated cultures on patients who fail to respond in the anticipated way will serve to detect increasing tolerance of the gonococci to the sulfonamide drugs. The data presented serve to re-emphasize that the diagnosis of sulfonamide-resistant gonorrhea should be made only after proper bacteriologic study. They also support the concept that resistance is less apt to develop toward sulfathiazole than toward sulfadiazine.

Since many of the "drug-resistant" cases of gonorrhea were treated with penicillin an effort was made to correlate the clinical with the bacteriologic findings. The method of study was similar to that described except that penicillin in concentrations of 5 and 1 Oxford unit per ml. was incorporated into the media. The growth of 181 strains of gonococci including those which had proved to be refractory to the action of sulfonamides was completely inhibited by a concentration of 5 units. An additional 66 strains from clinically-resistant cases failed to grow in the presence of 1 unit of penicillin. The final value of 1 unit of penicillin per milliliter was selected following pure culture studies with numerous strains of gonococci.

Organisms plated on varying concentrations of this drug proved to be remarkably susceptible to its action. The minimal amount of penicillin capable of inhibiting the growth of six pure cultures of gonococci was determined. When the concentration was reduced to .01 units, four strains grew maximally, one showed partial inhibition, two colonies appeared with another, and the sixth culture failed to grow at all. To date four of the above strains have been cultured

for 25 passages on increasing concentrations of penicillin. All now grow maximally on .01 unit but we have not been able to maintain growth on .05 or even .025 unit of the drug. Apparently penicillin resistance is difficult to establish.

During the course of therapy the gonococci disappear within forty-eight hours from the genito-urinary tract in the majority of cases. Occasionally they were present for as long as two weeks and subsequently the prostatic and urethral cultures became negative and the patients were classified as cured. Since no other forms of therapy were used, it must be assumed that the results were due, either to a delayed effect of penicillin not detectable by present methods or to a modification of host-parasite relationships induced by the drug. A total of 100,000 Oxford units given in divided dosage of 20,000 units every three hours was most effective.

Recently we have studied two patients who were admitted with the clinical diagnosis of penicillin-fastness. One had received 310,000 units of penicillin at another general hospital. Repeated smears and cultures were taken but we were unable to recover gonococci. The second patient had been given one 50,000 unit and another 100,000 unit course without improvement, and was referred to this station for fever therapy. Gonococci obtained from the urethral exudate were studied in pure culture on plates containing varying amounts of penicillin, and proved to be fully sensitive to the bactericidal action of the drug. This patient recovered completely following the administration of 100,000 units of penicillin.

Summary

1. Some of the factors involved in the treatment of sulfonamide-resistant cases of gonorrhea are discussed. A method for detecting bacteriologic resistance is described and the results are analyzed.

2. Sulfonamide-resistant gonococci are shown to be fully susceptible to the action of penicillin. Treatment in relation to bacteriologic cure is discussed.

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Pneumococcus Type III Meningitis Complicating Diabetes Mellitus

Recovery With Chemotherapy and Penicillin

By J. Lewis Dill, M.D.
Detroit, Michigan

■ THE case reported is of otitic origin and a proved type III pneumococcus meningitis complicating diabetes mellitus. Therapy consisted of a simple mastoidectomy and the administration of sulfadiazine and penicillin simultaneously.

Report of Case

On February 22, 1944, G. R., a colored man, forty-two years of age, was admitted to the hospital about 9:30 p.m. in a semicomatose condition. He was confused and unable to co-operate. The history was obtained from his wife.

Patient contracted influenza on December 22, 1943, and was so ill that he remained in bed for twenty days. During that time he had severe headache, particularly over the right parietal region. He returned to work January 20, 1944, and worked about two weeks. While at work and about three weeks before admission he developed pain in the right ear. Attacks of dizziness occurred and patient was sent home from work. These dizzy spells recurred two to three times a week and were not accompanied by nausea or vomiting. A paracentesis of the right drum was performed one week before admission. The ear drained profusely at the onset, but the discharge diminished considerably in amount. During the week before admission the patient had a bursting headache which confined him to bed. The appetite remained good. He remained clear mentally until 6:00 a.m. on the day of admission when he was found in a confused state. All day he was very restless, slept at long intervals and was admitted at 9:30 p.m.

Physical examination on February 22, 1944, was as follows:

From the Division of Otolaryngology, Henry Ford Hospital.
The penicillin was obtained from the National Research Council through the courtesy of Dr. Chester S. Keefer, Boston, Massachusetts.

PNEUMOCOCCUS TYPE III MENINGITIS—DILL

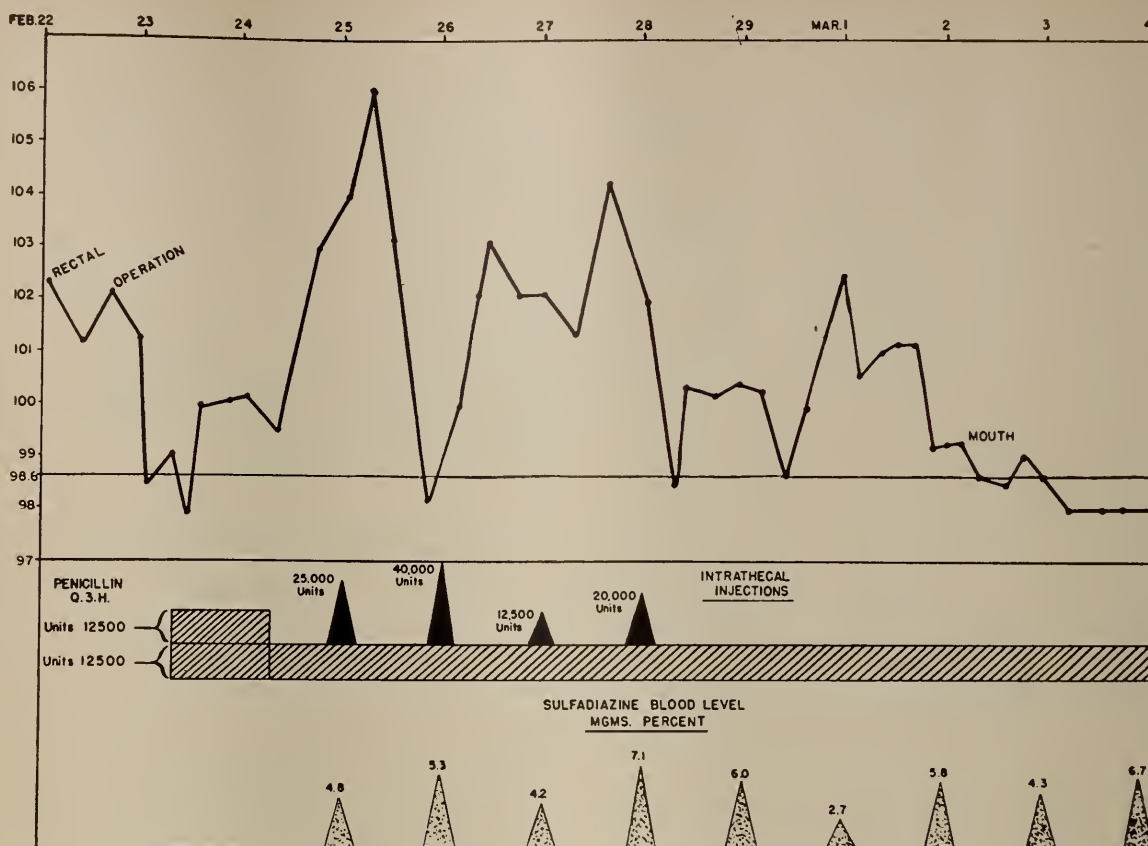


Fig. 1. Graphic record. Temperature is illustrated for the first eleven days after which temperature remained normal.

Patient: A well-developed, colored male, rather confused with occasional lucid intervals but unable to co-operate.

Heart and lungs: Negative. Blood pressure 118/74.

Eyes: React to light and accommodation. Fundi normal. No nystagmus.

Ears: Left canal clean, drum intact. Right canal filled with discharge.

Neurologic examination: Well-marked neck rigidity. Positive Kernig and Brudzinski.

Hemoglobin: 13.5 grams. White blood count 7,250. Blood sugar 270 milligrams per cent.

Lumbar puncture: Fluid cloudy; 700 cells; 28 milligrams mercury pressure. Culture—Pneumococcus type III.

Urine: Sugar 4+

Wassermann: 4+

The patient was given insulin, intravenous glucose and 5 per cent solution of sulfadiazine intravenously.

During the night the patient was delirious and it was difficult to administer intravenous therapy. The white blood count was 21,800 and polymorphonuclears 94 per cent. X-ray revealed clouding of entire right mastoid. No cells were seen.

On February 23, 1944, simple mastoidectomy under ethylene anesthesia was done.

The cortex of mastoid was densely hard. Mastoid cavity was large, filled with pus and granulations. Cells were all destroyed. The dural plate was necrotic and

was removed. Dura appeared normal. The entire lateral sinus was exposed by disease. The sinus wall was thickened and covered with granulations, but the sinus appeared to be patent. Disease had outlined the labyrinth and the semi-circular canals.

The same night treatment with penicillin was started. Patient was given 25,000 units intrathecally and 25,000 units intramuscularly every three hours for twenty-four hours and then 12,500 units were given every three hours.

February 24—Patient rational, answered questions, felt improved.

February 25—Temperature 103.2 F. at 2:00 p.m. At 10:30 p.m. temperature was 106 and patient was drowsy and lethargic.

February 26—Patient improving. Temperature slowly subsiding. White blood count was 41,000.

March 1—Transfusion, 600 c.c. citrated blood. Temperature normal. Patient improved.

Since March 1, 1944, the temperature remained normal (Fig 1) and the patient felt well. The white blood count gradually decreased and on March 10 was 9,850. Repeated cultures of the spinal fluid were negative and cell count of spinal fluid was 75 cells on March 3 and 60 cells on March 8.

Sulfadiazine was administered for fifteen days. For the first forty-eight hours a 5 per cent solution was

(Continued on Page 635)

Our Ten Million Dollar Baby

In five years, Michigan Medical Service has paid to the doctors of Michigan over ten million dollars for services rendered. During the year 1945 alone, it is expected that approximately five million dollars will be paid for medical care.

Out of 5,300,000 people in this state, Michigan's voluntary group medical care plan had 790,526 subscribers enrolled on May 1, 1945; new subscribers are being added at the rate of 6,000 a month. Whenever recoverage has been in force the percentage of enrollment increases from year to year, indicating enthusiastic reception on the part of the public.

At the present time, Michigan Medical Service offers surgical coverage in the hospital; it is embarking upon the program of surgical-and-medical coverage in the hospital and will have offered this service by the time this page is printed.

Michigan Medical Service covers the worker's wife and dependents with exactly the same coverage as is accorded the worker; this includes obstetrical services for the wife. Family coverage is unique among medical service plans and naturally merits overwhelming public approval.

Overhead costs for administering Michigan Medical Service runs at the extreme low of 11.4 per cent; in England, under the Panel System (government control), over 80 per cent goes for other than payments to physicians.

The medical profession of Michigan has met the demands of the public; our doctors of medicine have offered the people something that cannot be duplicated by any form of government medicine.

The largest and most successful voluntary prepayment medical care program in the world—whose experience to date is twice as great as that of all other medical service plans combined—is far from being "delicate" (as described by an advocate of mass industrial medicine). Michigan Medical Service is a robust, radiant, ten-million-dollar baby!



President's



Page



As Brunk

President, Michigan State Medical Society

Editorial

ANOTHER FIRST FOR MICHIGAN

■ ON invitation by Andrew S. Brunk, M.D., President of the Michigan State Medical Society, the Presidents or Presidents-elect of seventeen State Medical Societies met in Detroit, April 27 and 28, 1945, as guests of the Michigan State Medical Society. They were:

Joseph H. Howard, M.D., Bridgeport, President-elect, Connecticut State Medical Society
I. L. Chipman, M.D., Wilmington, President, Medical Society of Delaware
Wm. M. Ballinger, M.D., Washington, Acting President, Medical Society of District of Columbia
E. P. Coleman, M.D., Canton, President, Illinois State Medical Society
N. K. Forster, M.D., Hammond, President, Indiana State Medical Society
R. D. Bernard, M.D., Clarion, President, Iowa State Medical Society
O. O. Miller, M.D., Louisville, President, Kentucky Medical Society
E. S. Bagnall, M.D., Groveland, President, Massachusetts Medical Society
A. S. Brunk, M.D., Detroit, President, Michigan State Medical Society
E. L. Tuohy, M.D., Duluth, President, Minnesota State Medical Association
E. L. Rogers, M.D., Lincoln, President, Nebraska State Medical Association
J. F. Londrigen, M.D., Hoboken, President, Medical Society of New Jersey
H. H. Bauckus, M.D., Buffalo, President, Medical Society of the State of New York
L. Howard Schriver, M.D., Cincinnati, President, Ohio State Medical Association
William Bates, M.D., Philadelphia, President, Medical Society of the State of Pennsylvania
Elihu Wing, M.D., Providence, President, Rhode Island Medical Society
Charles Fidler, M.D., Milwaukee, President, State Medical Society of Wisconsin.

Also present were:

E. J. McCormick, M.D., Toledo, Past President, Ohio State Medical Association, and Member, Council on Medical Services and Public Relations, A.M.A.
L. F. Donohoe, M.D., Bayonne, Past President, Medical Society of New Jersey
A. A. Brindley, M.D., Toledo, Councilor, Ohio State Medical Association
J. B. Lukins, M.D., Louisville, Chairman Medical Economics Committee, Kentucky State Medical Association
J. E. Farrell, Providence, Executive Secretary, Rhode Island Medical Society

T. A. Hendricks, Executive Secretary, Indiana State Medical Association

Mac F. Cahal, Chicago, Secretary, American College of Radiology

The Michigan Executive Committee and others

The guests were assembled and quartered at the Wardell-Sheraton Hotel, and taken to the Detroit Athletic Club for a luncheon meeting with the Executive Committee of the Council where a short discussion of the "Drafting Panel" was led by P. L. Ledwidge, M.D., Speaker of the MSMS House of Delegates, and E. L. McCormick, M.D., of Toledo, Member of the Council on Medical Service and Public Relations of the AMA. This discussion outlined the "Drafting Panel" appointed by the Executive Committee of the Council of the Michigan State Medical Society and its studies looking towards a program of positive health legislation sponsored by the medical profession.

The discussion attracted much interest, and resulted in a resolution urging that similar panels be set up in other states represented, and that states not represented be invited and encouraged to join in this progressive work. Dr. Tuohy in his remarks in the discussion said, "I hope there will be developed, from this meeting of the Medical representatives of seventeen States here assembled, plans through which Medicine will continue to be a free and unregimented profession with dignity, and the preservation of its American function namely, *Service to Our Fellow Man*."

After luncheon, the party visited the headquarters of Michigan Medical Service in the Washington Blvd. Building, Detroit, and toured the eleven floors housing the administrative, personnel, equipment, methods and records of Michigan Medical Service, Michigan Hospital Service, and the Michigan Health Council.

The evening was spent at the Public Relations dinner of the Michigan State Medical Society at the David Whitney House, headquarters of the Wayne County Medical Society. As the guests were seated the April 3 telephone conference in which the seventeen state medical society presidents participated was reproduced.

At 7:15 p.m., following an announcement by President Brunk, the regular weekly radio pro-

gram of the Michigan State Medical Society, entitled "American Medicine" broadcast from Radio Station WJR every Friday, was tuned in.

President Brunk, as Toastmaster, welcomed the guests:

"Seldom, if ever before, have the chief executive officers, the presidents of seventeen active state medical societies, been gathered together, as tonight. Our unique and rare privilege is to welcome you as our guests here in Michigan. We have met for mutual assistance in promoting better distribution of medical care, better public relations, and in preserving the time-tried private practice of medicine, and the physician-patient relationship which, to quote our radio speaker tonight, have made American Medicine the greatest in the world.

"We greet you presidents and the other officers of the sixteen state medical societies who have journeyed to Detroit at our invitation.

"We are happy also to welcome our many Michigan friends, both in and out of the profession, for their kindness in being with us tonight."

C. F. Kettering, Vice President in charge of research of the General Motors Corporation, Detroit, spoke to the assembled guests on "What Can an Industrial Research Laboratory do for the Medical Profession?" (to be published in a later issue).

There was extended discussion of the Radio Program, of Michigan Medical Service, and of the Drafting Panel. Upon motion by N. K. Forster, M.D., Indiana, a committee was appointed "to study the feasibility of commercial radio broadcasting, as related to the various states here represented, in co-ordinating and co-operating in the development of such programs, and to make recommendations for the best methods of carrying out such a program."*

The following resolution was presented to the Conference by a committee composed of P. L. Ledwidge, M.D., Michigan, Chairman; E. S. Bagnall, M.D., Massachusetts; R. D. Barnard, M.D., Iowa; J. F. Londrigen, M.D., New Jersey; and L. Howard Schriver, M.D., Ohio:

BE IT RESOLVED,

1. That this group expresses its continued loyalty to the American Medical Association;
2. That it is the duty of the various state medical societies to advise the American Medical Association, through its Council on Medical Service and

Public Relations, of their wishes in regard to national health legislation;

3. That the presidents of the several states and District of Columbia medical societies, or their representatives, act as a permanent committee immediately to set up Drafting Panels in each state for this purpose;
4. That states not represented here today be invited and encouraged to join in this work;
5. That the President of the Michigan State Medical Society be designated as temporary chairman of this committee to facilitate its activities.

Motion of Drs. Barnard-Bagnall that the report of the committee be accepted was carried unanimously. Discussion brought out that each State Drafting Panel should develop its own ideas; subsequently, representatives from all the states should meet to develop a correlated program.

* * *

A tour of Willow Run, the bomber plant of the Ford Motor Company arranged through the courtesy of Roy McClure, M.D., Surgeon-in-Chief of Henry Ford Hospital, was enjoyed on Saturday by most of the visitors. Others attended the monthly meeting of the Executive Committee of the Michigan State Medical Society.

Motion by Dr. Londrigen, seconded by all, "that the group give a rising vote of thanks to the Michigan State Medical Society, which through its forward-looking activities and its worth-while and well-planned conference of this day has brought such comfort and help to the entire medical profession."

A BROAD MEDICAL CARE PROGRAM

■ OUR readers will appreciate that we have long been leading up to a philosophy and program of medical service that will be aggressive, well planned, and will cover the needs of the people seeking medical care. We believe that the best interests of our people, of ourselves, of each individual is not to guarantee to them all the luxuries or necessities of life, but to guarantee to them the ability of securing by their own efforts the benefits they need.

Our forefathers carved out their destiny and ours by hard labor, and the boldness to strive for the right to live independently. They established a rugged nation that is the pride and ambition of all the world. This was not done by having their wants guaranteed to them by paternalistic gov-

*Committee: E. S. Bagnall, M.D., Massachusetts; Herbert H. Bauckus, M.D., New York; A. S. Brunk, M.D., Michigan; E. P. Coleman, M.D., Illinois; N. K. Forster, M.D., Indiana; Joseph H. Howard, M.D., Connecticut; L. Howard Schriver, M.D., Ohio.

ernment. They made nature and their government subservient to *them*.

The Executive Committee of the Council of the Michigan State Medical Society, believing that some changes in methods of medical practice and distribution of medical care are inevitable, and believing that it is time for Medicine to stop playing a defensive game, and start carrying the ball, have determined to help guide the group thinking which must be encouraged to lead the profession in the interminable skelter of plans and schemes to furnish medical care for the people, and attempts to regiment and control the practice of medicine. Knowing that this leadership must now be asserted, they appointed a Drafting Panel at the March 22, 1945, meeting.

The Drafting Panel consists of L. Fernald Foster, M.D., Bay City, Chairman, Wilfrid Haughey, M.D., Battle Creek; Stanley W. Insley, M.D., Detroit; H. M. Pollard, M.D., Ann Arbor, and A. B. Smith, M.D., Grand Rapids. This committee has been actively at work and has prepared an outline, the result of first studies, not complete, but published in this number of the Journal, page 585, for the information of our members and to invite opinions and ideas that should be considered.

THE OVERTIME THAT KILLS

■ DOCTORS are realizing that their incomes are greater, because they are paying larger income taxes. They have suddenly stepped into a group on which the government is leaning heavily to support the war, a group to which most of them have been strangers.

While the doctors are recognizing the increase of earnings, the gross returns from their practice, most of them FORGET that this increase is due to ONE thing: *overtime*. They are laboring three times as hard as formerly, killing themselves, or shortening their lives by their strenuous efforts to bring needed care to the people. (In the past few months we have lost by coronary disease the President-Elect of our Society, two secretaries of County Medical Societies, and the Chairman of one of the State Society Committees, as well as scores of members—an all-time high.)

These increased incomes which are costing so many valuable lives, lives which the public cannot afford to lose, are based on increased hours

of work. The fees have not been raised. No. Only the hours have been increased; the ordinary fees remain. Taxes have been increased, and the surtax percentage.

Net: As far as net income is concerned, the doctors are not much better off with the triple run of today than they were when they worked single step. The ultimate result is an irreparable loss to the profession and to the public whose medical care must of necessity be less detailed. There are not enough doctors of medicine, and those at work are taxed to the limit of endurance.

Critics of doctors' increased income ignore the overtime that kills. The law fixes weekly hours for labor, and designates all else as overtime at time and a half; not so the doctor.

ON THE RUN . . .

Chancroid (Ducrey's bacillus) undergoes rapid involution with either sulfathiazole or penicillin therapy.

• • •

In hyperparathyroidism the size of the offending parathyroid adenoma is directly proportionate to the increased level of ionized calcium in the blood plasma.

• • •

Bronchiogenic carcinoma is predominantly a male disease.

• • •

Increased blood uric acid and gout may occur in leukemia, familial hemolytic jaundice and pernicious anemia.

• • •

Competency of circulation in the extremities may be determined by the intravenous injection of a sterile solution of radioactive sodium and use of a Geiger counter.

• • •

Headaches occur only in sinusitis complicated by allergy.

• • •

Skin can live twenty-four hours to forty-eight hours without nourishment; muscle can withstand no more than six to eight hours ischemia.

• • •

In the serologic diagnosis of typhus, a single Weil-Felix (OX19) reaction is untrustworthy, but repeated tests showing a rising titer, furnish the most valuable diagnostic sign.

• • •

Fluorine intoxication may be prevented best by an adequate diet high in calcium.

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Communications

TUBOVASCULAR GASTROSTOMY

A paper of this title appeared in the February number of *THE JOURNAL*, and March 17, 1945, the Editor received a vigorous protest from Professor Spivack demanding space for a full refutation of the contents of the paper. We replied that space would be made for a short statement to the editor, and a reply from Dr. Thorek, after which the incident would be closed so far as this *JOURNAL* is concerned.

We are presenting the two letters addressed to the editor, with this introductory statement.—THE EDITOR.

To the Editor:

In the February issue of your valued *JOURNAL* appeared an article by Dr. Max Thorek under the title¹: "Tubovalvular Gastrostomy. History and Technique," which is replete with misstatements. Even a casual reader cannot but gain the impression that the article has been prompted more by hatred for Spivack than the search for scientific truth.

Thorek tries to show that the valve was created by Pénieres and Fontan, the tube by Depage and the combination of the tube and the valve by Watsudji.

What are the facts?

I. Who constructed the valve?

(a) Pénieres⁴, in 1893, published an article in which he claimed that by doing a two-stage gastrostomy, the gastric mucosa becomes elongated, thus forming a "mucosal valve." Therefore, according to Thorek, Pénieres is the originator of valvular gastrostomy. However, the literature shows that Pénieres was neither the originator of the word "valve," nor of a new technique. The word "valve" has been used by Sédillot¹ in 1853, when describing his metallic cannula, he wrote that it consists "of two halves or valves" and by Witzel¹³, in 1891, who stated that the channel formed by him has a *valvular* action. As far as two-stage gastrostomy is concerned, in the time of Pénieres it was already an obsolete operation: Egeberg, in 1837, already suggested that gastrostomy should be performed in two stages, and as such it actually was done by Van Thaden in 1867, Schoenborn in 1876, Pelech in 1881, to mention only a few. It just happened that Pénieres was unaware of their work.

(b) Fontan³, in an article published in 1896, described a technique consisting of folding the anterior gastric wall, suturing the edges together, leaving only a small ring in the middle of the folds and by making an opening at the bottom of a cul-de-sac thus produced he formed a "channel, resembling a bishop's mitre; the valve is thus constructed."

However, the doubling of the wall and its transforma-

(Continued on Page 612)



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COMMUNICATIONS

(Continued from Page 610)

tion into a valvular channel has been done long before Fontan by Witzel in 1891, by Stamm in 1894 and simultaneously by Kader. Fontan's technique is an actual repetition of the Stamm method, *who preceded him by two years*. This is the reason that such eminent surgeons as Keen, Moynihan, Finney, Mikulicz, and Kirschner do not even mention the name of Fontan, fully giving credit to Witzel or to Stamm.

(c) *Is the valve made by me identical with the valve made by Witzel (Stamm, Kader, Fontan)?* Their valves wholly differ from mine. In their methods the valve is formed by doubling the gastric wall and *transforming the formed cul-de-sac into a channel by making an opening at its bottom, whereas in my method the doubled gastric wall is not transformed into a channel but remains a solid piece of doubled gastric wall*. In their methods it is a channel, in mine—a living plug.

II. Who created the tube?

(a) Thorek implies that I claim to be the originator of the tube. Nothing could be farther from the truth: In my original article⁵, published in 1929, *long before Thorek ever wrote anything on gastrostomy*, I gave full credit to Depage for being the originator of the tube, and Thorek knows this well. The readers will be amazed to learn, that Thorek¹⁰ in one of his previous articles wrote: "Spivack justly gave credit to Depage for originating the tube." Thorek evidently does not subscribe to the ancient admonition: "Thou shalt not bear false witness against thy neighbour."

III. Who was the first to combine the tube and the valve?

Thorek claims that this was performed first by Watsudji in 1899. It is a matter of common knowledge that Depage² described the tube only in 1901 and, therefore, Watsudji could not use a tube two years before it was described. As a matter of fact, Watsudji never claimed to have combined a valve and a tube. What he did claim is that he carried the valvular channel of Fontan through the abdominal wall in such a manner that the fibers of the rectus muscle were compressing this channel thus rendering the stomach watertight. *In no place does Watsudji even mention the word "tube."*

The originator of the tubovalvular method is Spivack who combined the tube and the valve. This is recognized by the entire surgical world. Papers were written on this subject in different countries, all of them praising the method and giving Spivack full credit as its originator.

IV. What prompted Thorek to attack my name for the last eight years by writing scurrilous articles?

Thorek claims that his continuous writings on gastrostomy in which my name and method is the invariable topic are prompted by a noble desire to rectify the errors he committed in his early writings when he

(Continued on Page 614)



Reserves for G. U. Infections

When sulfonamides cannot be employed in genito-urinary infections, the alert physician utilizes the time-tried reserve of the azo dyes. Serenium, a therapeutically-effective dye, has the distinct advantage of being analgesic to the inflamed mucous

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COMMUNICATIONS

(Continued from Page 612)

"stumbled in a literary trap" prepared by me. Why did no one else fall in this trap? In my original article⁶ I gave thirty-one literary references, which is more than the combined number of references given by Pénieres, Fontan, Witzel, Stamm, Kader, Depage, Janeway and Watsudji! This certainly is a great amount of articles that would prevent anyone from falling in a trap. Or does Thorek wish to say, that when he wrote his article⁹ in 1931 he never read anything on gastrostomy before and my article was his only source of information on this important subject?

No, I never "trapped" Thorek. He "trapped" himself, in 1933, when he started to plagiarize Pribram's mucoclasia operation calling it "Thorek's Operation" ("Cholecystoelectrocoagulectomy"). I was only a faithful historian, who in my book "The Surgical Technic of Abdominal Operations" published in 1936, gave full credit to Pribram. Thorek "trapped" himself again in 1936, when he started to plagiarize a slight modification of my gastrostomy by publishing an article⁹ in Italy. I rebuked him in the same journal⁷, showing that he is a plagiarist, pure and simple. This exposure of Thorek as a plagiarist prompted him to write a series of articles on gastrostomy, and not "a noble desire to rectify his errors."

JULIUS L. SPIVACK, M.D., LL.D.
Associate Professor of Surgery,
University of Illinois College of Medicine

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To the Editor:

Spivack's letter is designed to mislead, offend, and obscure truths. Since I believe with Shakespeare to "tell the truth and shame the devil," I presented proofs and reproductions of original articles from the literature, that Spivack had nothing to do with the principles of tubovalvular gastrostomy. I stand firm on these

(Continued on Page 616)

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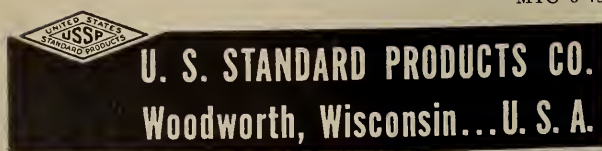
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COMMUNICATIONS

(Continued from Page 614)

proofs. I ask the reader to keep the following proven facts in mind:

- (1) that L. Pénieres⁸, made continent leakproof valves, *thirty-six years before Spivack's article appeared.*
- (2) that Fontan⁵, made leakproof valves *thirty-three years before Spivack's article appeared.*
- (3) that Dépage³, made tubes from all layers of the stomach *twenty-eight years before Spivack's article appeared.*
- (4) that Watsudji¹², combined Fontan's and VonHacker's operation thirty years before Spivack's article appeared (see references).

Now, *what did Spivack do?*

In 1929, Spivack combined Fontan's valve with the Dépage and Janeway tube on nine dogs¹⁰ (not on a single human being). He promptly presented a camouflaged article on "*A New Method of Gastrostomy (sic) ignoring the pioneers and appropriating all the credit to himself.*"

Is this not flagrant surgical plagiarism? It puts Münchhausen to shame!

After sixteen years, Spivack *completely unmasks himself* by the literature, which he cites *for the first time* in his letter to the editor. He quotes the same references I presented above (Pénieres⁴; Fontan³; Watsudji¹² Dépage², thus *proving my contentions.*

In his first article and *only* article, on "A New Method of Gastrostomy¹¹," Spivack never mentioned the work of Pénieres, Watsudji, and garbled Fontan's work. Nor has he mentioned these pioneers elsewhere in all these years. Is it possible that he just learned these things from me?

Spivack asks: (I. a, b, c) "Who constructed the valve?"; (II. a) "Who created the tube?"; (III.) "Who was first to combine the tube and valve?" *In his letter to the editor, Spivack, himself, offers unequivocal proof that it was not he who created the tube and valve in gastrostomy.* Now he claims credit only for combining them. He says: "The originator of the tubovalvular method is Spivack *who combined the tube and the valve*" (italics mine). That eliminates him as an originator of either tube or valve. He can, therefore, no longer speak of a "new operation." Furthermore, since the father of the "combination principle" is Watsudji to whom Spivack gives credit *for the first time*, who combined the VonHacker and Fontan operation, how can Spivack claim credit for a combination principle in which he was preceded by Watsudji thirty years? He should have followed the example of Watsudji in announcing which operations he combined (Fontan's and Dépage's). This he failed to do.

Spivack's bold statement that he is recognized by the "*entire surgical world,*" as the "originator" (sic) of this operation, and that "*all of them*" (sic) "*praise his method*" is not true. Proof: (a) Dr. Robert C. Fer-

(Continued on Page 618)

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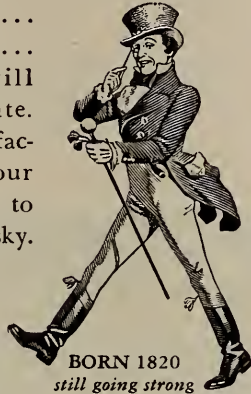
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COMMUNICATIONS

(Continued from Page 616)

rari and Miguel Correa Iturraspe of the University of Buenos Aires⁴, conclude: "The so-called Spivack tubovalvular procedure is based upon the tubovalvular gastrotomy of the valvular gastrotomy of Fontan, Pénieres and Senn." As to everybody "praising the method," this also is untrue. Proof: (b) Resano J. Horacio says: "Spivack's method which theoretically appears so brilliant has in practice given rise to many failures."

Spivack asks why no one else fell into his literary trap. There were others. Proof: Nelson H. Lowry and S. Soresen⁶, also stumbled into the same trap because they depended solely upon Spivack's only nine-dog article, as did I. All others who did not consult the literature were equally misled and hoodwinked.

Spivack boasts that he supplied thirty-one references in his only article, but he failed to mention the most important ones: Fontan's, Pénieres', and Watsudji's, which prove him a pilferer. After all these years, he offers them now for the first time.

Spivack's remarks about "rebuking me" in the *Rassegna* is false. It was Spivack who was rebuked for rifling the work of others.

To deflect the spotlight from his literary pilferings, Spivack interjects irrelevant matters. One might ask, "What have my other operations to do with gastrotomy? Absolutely nothing, except Spivack's desire to "smear" and make a "show." But here again Spivack stuck his neck out. His own words condemn him. The literature shows that the Pribram and Thorek operations are two entirely different procedures. In his book, page 490, Spivack gives credit to Pribram for *mucoclasia* and to myself for my operation on *electrosurgical obliteration of the gall bladder*. Spivack criticizes Pribram by saying: "Several objections have been raised against Pribram's method," and he pats me on the back by asserting, "Thorek operated on 143 cases by cholecystelectrocoagulectomy without a single death"^{1,2,7,12}.

Spivack laments that I hate him. I am incapable of hating anybody. I regret that after befriending him for years, I discovered a stiletto between my scapulae.

Eliminating Spivack's rancorous aspersions, his letter proves my contentions to be fully established, viz., that he contributed nothing new.

Rugged Americansim considers it a duty to unmask any imposter who attempts to appropriate credit to himself for the labors of others. We all agree with Mme. de Staël, that "search for the truth is the noblest occupation of man; its publication is a duty."

MAX THOREK,

Professor of Surgery, Cook County
Graduate School of Medicine

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(Continued on Page 620)

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(Continued from Page 618)

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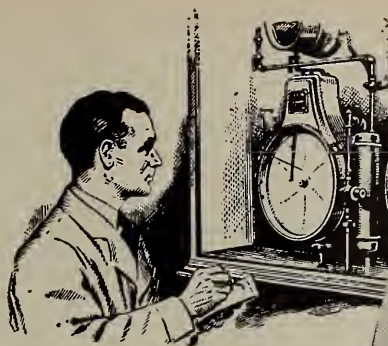
3. Without proper laboratories, equipment, and experience it is relatively impossible to control contaminations. These contaminants may result in the presence of toxic substances *per se*, or they may destroy any penicillin which is present, and render the final product valueless.

4. The concentrations of penicillin in crude media rarely exceed 25 to 50 units per ml. This concentration of penicillin is so far below therapeutic dosage that it is highly improbable that they would be of any value, and would result only in needless sensitization to the proteins of the media or the organisms themselves.

5. No doubt most physicians would apply their "home made" penicillin topically, or in wet dressings. This would provide ideal conditions for the multiplication of the usual skin organisms, and constitute a real danger.

6. Even under the best production conditions penicillin frequently contains a high concentration of pyrogens. These pyrogens are unusual in that they are supposedly nonfiltrable. This indicates only that even the best producers know practically nothing about penicillin as yet.

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Franklin Lye Watters of Detroit was born in Rome, New York, June 6, 1909, and was graduated from Syracuse University in 1935. Completing one year's internship at the Highland Park Hospital, the following year he established offices in Highland Park to practice industrial medicine. Captain Watters enlisted in the Air Corps in 1942, spending his first assignment at Selfridge Field until September of that year. He was then transferred to Randolph and Kelly Fields, where he completed his course in Flight Surgery. He was assigned to the 38th Bomber Group and embarked for overseas in June, 1943; awarded the Silver Star and Purple Heart; received the Soldier's Medal for rescue work at an American Base in England; and posthumously awarded the Oak Leaf Cluster to the Soldier's Medal for heroic rescue in which he lost his life; killed by explosion of bombs while rescuing trapped fliers from a burning crashed bomber in France, December 9, 1944.

E. B. Andersen of Iron Mountain was born March 2, 1893, in Drammen, Norway, and was graduated from the University of Michigan in June, 1919. After graduation he served as intern and house physician for two years at Blodgett Memorial Hospital, Grand Rapids. He opened an office in Grand Rapids in 1929 and remained there until 1936 when he located in Iron Mountain. He was a past president of the Kiwanis Club. At the time of his death he was long-time secretary of the Dickinson-Iron County Medical Society, and had served as Chairman of County Society Secretaries in 1942. Dr. Andersen died April 22, 1945.

* * *

Merton O. Blakeslee of Lapeer was born August 15, 1879, at Brown Helm, Ohio, and was graduated from the University of Michigan Medical School in 1913. He practiced in Jackson and Parma in 1913 and 1914 and was health officer in Jackson from 1915 to 1917. For the next four years he engaged in private practice in Ionia. From 1920 to 1928 he was assistant superintendent of the Lapeer Home, and from 1928 to 1934 was superintendent of the New Mexico Home and training school in Los Lunas. He returned to Lapeer in the fall of 1943. At the time of his death he was superintendent of the Lapeer Home and Training School. He died February 11, 1945.

* * *

Basil L. Connelly of Detroit was born in 1893 in Ohio and was graduated from Western Reserve Medical

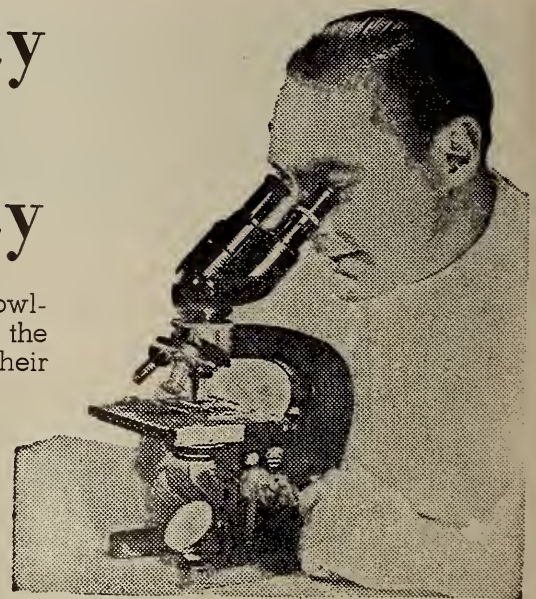
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School in 1920. Dr. Connelly interned at Harper Hospital in Detroit and was gynecological resident at receiving hospital for three years. He was a staff member at St. Mary's East Side General, Florence Crittenden, Women's, Grace and Mt. Carmel Mercy Hospitals. Dr. Connelly practiced medicine and surgery in Detroit for more than twenty years and was a very active member of the Wayne County Medical Society, serving as delegate to the State Society for a number of years. He died April 1, 1944.

* * *

George L. G. Cramer of Owosso was born in Burton on September 25, 1864, and was graduated from University of Michigan Medical School in 1889. He first practiced in Baraboo, Wisconsin, for fifteen years, but in 1904 he returned to Owosso to practice. Dr. Cramer was one of a group of physicians who were responsible for the founding and building of the present Memorial Hospital of Owosso. He served as chief of staff during the first two years of its operation and maintained an active interest in the institution up to the time of his death. He was a past president of the Shiawassee County Medical Society and an Emeritus Member of the Michigan State Medical Society. He died April 3, 1945.

* * *

Ernest N. D'Alcorn of Muskegon was born November 12, 1896, in Chicago; was graduated from the University of Illinois Medical School in 1920. He served his internship in Metropolitan Hospital in New York,

JUNE, 1945

then came to Hackley Hospital, Muskegon. Subsequently he took postgraduate work at Lying-In Hospital, Chicago. In 1923, Dr. D'Alcorn started practice in Muskegon. For several years he directed obstetrics in Mercy Hospital and headed the same department in Hackley Hospital for seventeen years. He also served for five years as head of the gynecological department of Hackley Hospital. He was president of the Muskegon Medical Society in 1942. Dr. D'Alcorn died January 19, 1945.

* * *

F. H. Ferguson of Carson City was born June 24, 1873, in Canada and was graduated from the Medical Faculty of Trinity University, Toronto, 1901. He practiced in the vicinity of Alpena, Michigan, and thirty-two years ago located in Carson City, where he continued his medical work to the time of his death. Dr. Ferguson died February 12, 1945.

* * *

John F. Gruber of Cadillac was born in 1881 in Michigan and was graduated from Saginaw Valley Medical College in 1902. He practiced one year in Shepherd. The following year Dr. Gruber located in Mesick where he remained until he enlisted as an officer in World War I. He served in the front lines overseas as a captain in the Medical Corps. After returning from the war, he established his practice in Cadillac where he served that community until his last illness. He had been chief-of-staff at Mercy

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Hospital at different periods and was Wexford County coroner at the time of his death. Dr. Gruber died April 18, 1945.

* * *

S. A. Jackson of Muskegon was born March 16, 1890, in Muskegon and was graduated from the Detroit College of Medicine in 1916. Dr. Jackson was a member of the staffs at both Hackley and Mercy Hospitals, and was active in medical circles. He died January 2, 1945.

* * *

J. K. Jamieson of Paw Paw was born in 1873 and was graduated from the University of Illinois College of Medicine in 1907. After graduation he practiced in Chicago. Thirteen years ago he returned to Paw Paw to retire, but due to the war and the need for physicians he resumed active practice in 1942. He died January 12, 1945.

* * *

Guy C. Matthewson of Flint was born in 1882 and was graduated from the Detroit College of Medicine in 1916. He practiced in Elsie, Detroit and Chesaning before locating in Flint. For two years he served as examining physician at the Buick Motor Company and then returned to private practice. He died January 20, 1945.

* * *

J. G. Maurer of Saginaw was born November 22, 1877, in Frankenlust, Michigan, and was graduated from the University of Michigan Medical School in 1929. Dr. Maurer had practiced medicine in Reese thirty years,

had been retired from practice until 1942 when his son, Captain John A. Maurer, joined the Army Medical Corps, which influenced him once again to active work. He was president of Tuscola County Medical Society in 1928. Dr. Maurer died March 9, 1945.

* * *

Frederick B. Miner of Flint was born in 1876 and was graduated from Wayne University College of Medicine in 1906. Dr. Miner opened his practice in Flint as a pediatrician in 1907. He was one of the physicians who instituted the educational campaign which popularized iodized salt as a preventative for simple goiter. He served for years as the very active chairman of the Iodized Salt Committee of the Michigan State Medical Society. He was active in community health programs and civic affairs. He was former vice president of the Michigan Horticultural Society and specialized in chrysanthemums. He died April 27, 1945.

* * *

Gordon B. Moffat of Kalamazoo was born November 13, 1898, in Weston, Ontario, and was graduated from the University of Toronto Medical School in 1923. He interned for three years in Highland Park General Hospital. In 1930 and 1931 he became associated with the Detroit Health Department and then went to northern Michigan as a health director of Alpena, Cheboygan, Montmorency and Presque Isle Counties. Dr. Moffat came to Kalamazoo in 1942, to direct the county-city health unit. He died January 3, 1945.

IN MEMORIAM

Carl F. Snapp of Grand Rapids was born January 3, 1888, in Findlay, Illinois, and was graduated from Rush Medical College in 1915. He served his internship at the Presbyterian Hospital, Chicago, and then located in Grand Rapids. Volunteering in World War I, Dr. Snapp served overseas in the Army Medical Corps, Unit Q of Grand Rapids, as captain. In 1919, he resumed his practice in Grand Rapids. Dr. Snapp was president of the Grand Rapids Ear, Eye, Nose and Throat Society from 1928 to 1933, and president of the Southwest Michigan Triological Society in 1932. Dr. Snapp served as president of the Kent County Medical Society in 1934 and was one of its delegates to the Michigan State Medical Society. He died January 21, 1945.

* * *

John P. Watkins of Detroit was born October 26, 1882, at Anderson, South Carolina, and was graduated from Meharry Medical College at Nashville, Tennessee, in 1909. He continued his postgraduate studies at the University of Michigan Medical School. Dr. Watkins entered practice in Detroit in 1922 and was on the staff of the Wayne Diagnostic and Parkside Hospitals. He died January 24, 1945.

* * *

E. H. Webster of Sault Ste. Marie was born March 9, 1869, at Preston, Ontario, and was graduated from the Medical Faculty of Trinity University of Toronto in 1890. After graduation he took postgraduate work

in New York, specializing in otolaryngology. In 1892 he became company doctor for the Hall & Munson Co. at Bay Mills. In 1898 he went to Alaska as the doctor for the Sault Yukon Co. and subsequently returned to practice in Sault Ste. Marie.

* * *

E. G. Wilson of Jackson was born in 1877 and was graduated from the Michigan College of Medicine and Surgery in 1903. Dr. Wilson was a practicing physician in Jackson for more than forty years. He had been in active practice until last summer when ill health caused his retirement. He died at New Port Richey, Florida, on January 12, 1945.

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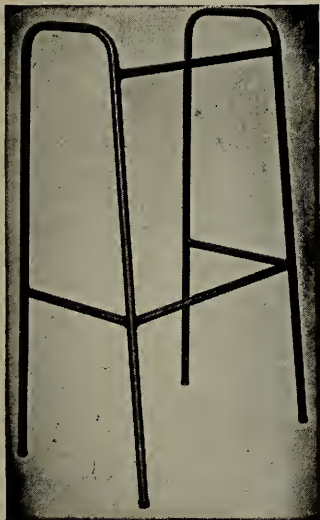
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BULLETIN

From June 1, the beginning of the fiscal year, to March 31, total subscriptions numbered 145; seventy-three of these are new.

BAY COUNTY

For the twelfth year, the Bay County Society for Crippled Children and Adults embarked on its annual Easter seal sale with the Bay County Medical Auxiliary undertaking the campaign.

Under the chairmanship of Mrs. George M. Brown, chairman for the third consecutive year, Auxiliary members packed the seals and addressed them to the thousands of sympathetic Bay City and county residents who each year contributed to the work.

Under the organization's plan, 50 per cent of the funds collected locally are used in Bay County, the balance going to the state fund to forward the work in Michigan. The seals went into the mails about mid-March and the campaign closed at Easter.

* * *

The Auxiliary held its March meeting at the home of Mrs. George M. Brown, Wednesday, March 14. Following dessert, Mrs. C. L. Hess, president, conducted a brief business meeting. Thirty-one members were present. The remainder of the evening was spent preparing seals and envelopes to be mailed for the Crippled Children's Seal Sale. This project is one of the outstanding activities of the Auxiliaries during the year.

KENT COUNTY

A. B. Smith, M.D., Council of the Fifth District of the Michigan State Medical Society, discussed pending legislation and Michigan State Medical plans at the luncheon meeting of the Women's Auxiliary to the Kent County Medical Society at their March meeting in the Browning Hotel. Mrs. Ward S. Ferguson, chairman of the legislative committee, was program chairman.

An exhibit of souvenirs sent home by local doctors serving overseas was arranged by Mrs. Carl Beeman, Mrs. A. Morgan Hill and Mrs. Paul Kniskern. The exhibit was contributed by Mrs. Richard C. Boelkins, Mrs. Fred C. Brace, Mrs. J. Russel Brink, Mrs. Charles M. Bell, Mrs. James Ferguson, Mrs. Stephen Hollander, Mrs. J. D. Miller and Mrs. C. Allen Payne.

MANISTEE COUNTY

A group of interested Manisteeans met at the Elks Temple, March 22, to hear Professor Paul Bagwell, Professor of Speech at Michigan State College, speak on

a proposal to amend the state constitution and provide a state-controlled setup for medical care and insurance.

The meeting was arranged by the Manistee County Medical Society and the Woman's Auxiliary.

Professor Bagwell has been prominent in activities of numerous civic organizations and home-front war agencies since joining the staff at Michigan State College in 1938.

Much of his outside service has been devoted to direction of Speakers' Bureaus for war bond rallies, civilian defense affairs and patriotic drives. In that connection he was chosen president of the National Victory Speakers' Conference in 1942, and since 1941 has been state director of the Michigan Victory Speakers' Bureau.

Professor Bagwell flayed the state medicine proposal as "paternalistic" and said it would cost employes and employers much more than it would be worth.

"The State of Michigan has set the pace for the Nation, and its voluntary Michigan Medical Service has been so constructive that every state in the nation is following its lead. There is no need for the proposed constitutional amendment or any similar legislation," the spokesman concluded.

ST. CLAIR COUNTY

At the March meeting held at the Chateau, projects of the State Medical Auxiliary were outlined by Mrs. H. L. French, Lansing, President of the Auxiliary to the State Medical Society. She was introduced by Mrs. James M. Atkinson, a friend of long standing—the two having attended school together.

DDT STUDIED FOR OUTDOOR USE HERE

Extensive investigations are now being conducted to determine the benefits and possible hazards involved in the contemplated use of the insecticide DDT on a large scale outdoors as part of a plan to control insect-borne diseases.

In the Pacific theater, DDT proved highly valuable in bringing insect-borne diseases under control. However, DDT will not be employed indiscriminately in this country until more research work has been completed on the general biological effects of this insecticide.

Besides killing insects that carry diseases, DDT may kill other insects that are beneficial—and thus affect the balance of nature which is important to agriculture and wild life. In combat zones, where the health of the soldier was at stake, it was necessary to ignore these considerations but in the United States general outdoor applications will not be adopted until more is known about these biological effects.—*Technical Information Bulletin*, Surgeon General's Office.

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Compliment

"In our opinion, no state medical association has made as great or as intelligent contribution to the future of the economics of medicine as the Michigan State Medical Society. It is my own personal belief that had the rest of the nation done as well, medicine would not today be faced with the continuing threat of bureaucratic control."—H. W. DETRICK, M.D., Secretary, Association of American Physicians and Surgeons, April 19, 1945.

* * *

Honors

Lt. Col. John M. Wellman, M.D. (Lansing, Michigan), is now Chief of Surgery at Lawson General Hospital, Atlanta, Georgia. Lawson has 2,500 beds and takes care of surgical cases only.

* * *

S. W. Insley, M.D., Detroit, was inducted as President of the Wayne County Medical Society at its annual meeting, May 7. The retiring president, L. W. Hull, M.D., presented the gavel and insignia of office to Dr. Insley in the lecture hall of the Detroit Institute of Arts.

In the annual election of officers, W. B. Harm, M.D., was chosen president-elect; Ralph A. Johnson, M.D., Secretary, and Wyman D. Barrett, M.D., Trustee.

* * *

Talks

C. L. Candler, M.D., Detroit, Chairman of the MSMS Special Committee on Radio, was guest speaker before the Executive Committee and the Public Relations Committee of the Massachusetts Medical Society in Boston,

April 1. The meeting was also attended by the presidents and secretaries of county medical societies of Massachusetts. Dr. Candler explained the broad public relations program of the Michigan State Medical Society and outlined the work of commercial radio broadcasting pioneered by the MSMS.

Dr. Candler also conferred with officials of the Medical Society of the State of New York and of the New York County Medical Society while he was in New York for several weeks doing postgraduate work.

* * *

A Public Relations Conference of Western States was called in Denver, June 28-29. The Michigan State Medical Society was invited to present the program, based upon that given at its Conference of 17 State Medical Society Presidents in Detroit on April 27. Speakers at the Public Relations Conference in Denver were Michigan's President A. S. Brunk, M.D., Detroit; Speaker P. L. Ledwidge, M.D., Detroit; Council Chairman E. F. Sladek, M.D., Traverse City, Secretary L. Fernald Foster, M.D., Bay City, and C. L. Candler, M.D., Detroit, Chairman of MSMS Special Committee on Radio.

* * *

Secretary L. Fernald Foster, M.D., and J. C. Ketchum, Executive Vice President of Michigan Medical Service, addressed the Philadelphia Co. Med. Soc., Philadelphia, Pa., on April 20. They spoke on "Beneficial Co-operation in the Interests of Doctors, Hospital, and the Public, of Blue Cross and Medical Service Plans."

* * *

Meetings

Council and Committee Meetings.

1. Executive Committee of The Council—Book-Cadillac Hotel, Detroit, March 22, 1945.
2. Legislative Committee—Porter Hotel, Lansing, March 25, 1945.
3. Committee on Procurement and Assignment Service for Doctors of Medicine—Book-Cadillac Hotel, Detroit, March 29, 1945.
4. Special Committee on Radio—Wayne County Medical Society, Detroit, April 2, 1945.
5. Drafting Panel—Book-Cadillac Hotel, Detroit, April 5, 1945.
6. Drafting Panel—Porter Hotel, Lansing, April 17, 1945.
7. Special Committee on Radio—Detroit, April 18, 1945.
8. Special Committee on Radio—Detroit, April 25, 1945.
9. Preventive Medicine Committee—Wayne County Medical Society, Detroit, April 26, 1945.

(Continued on Page 630)

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Meetings

(Continued from Page 628)

10. Executive Committee of The Council—Wardell Sheraton Hotel, Detroit, April 28, 1945.
11. Committee on MSMS Medical Veterans' Readjustment Program—Wardell Sheraton Hotel, Detroit, April 28, 1945.
12. Maternal Health Committee—Detroit, May 1, 1945.
13. Meeting with USPHS Representatives—Statler Hotel, Detroit, May 2, 1945.
14. Drafting Panel—Detroit, May 10, 1945.
15. Committee on Rheumatic Fever Control—Porter Hotel, Lansing, May 13, 1945.
16. Postgraduate Foundation Committee—Lansing, May 16, 1945.
17. Committee on MSMS Medical Veterans' Readjustment Program—Porter Hotel, Lansing, May 16, 1945.
18. Executive Committee of The Council—Porter Hotel, Lansing, May 16, 1945.
19. Committee on Venereal Disease Control—Porter Hotel, Lansing, May 20, 1945.
20. Joint Committee with State Bar of Michigan on Venereal Disease Control—Porter Hotel, Lansing, May 20, 1945.
21. Committee on Uniform Fee Schedules for Governmental Agencies—Book-Cadillac Hotel, Detroit, May 20, 1945.
22. Committee on Rheumatic Fever Control—Book-Cadillac Hotel, Detroit, May 20, 1945.
23. Midsummer meeting of The Council—July 13-14, 1945.

* * *

The Michigan Pathological Society held its regular bimonthly meeting at Woman's Hospital, Detroit, on the afternoon and evening of April 14, 1945. Dr. E. L. Potter, Pathologist, The Chicago Lying-in Hospital, Chicago, Illinois, acted as leader of the seminar on "Diseases of Fetus, Newborn and Placenta." Thirty-four members and twenty-one guests were present.

* * *

The American College of Chest Physicians announces that the next written examination for Fellowship will be held at Chicago, June 16. Candidates for Fellowship may contact the Executive Secretary, 500 North Dearborn Street, Chicago 10, Illinois.

* * *

Two clinic days sponsored by county medical societies were bright spots in the postgraduate program of the year:

(a) Ingham County Medical Society's Eleventh Annual Clinic of May 3 at the Olds Hotel, Lansing, attracted approximately 250 Doctors of Medicine from twelve south-central counties of Michigan. An outstanding program of guest speakers featured the day. The usual brand of Ingham County hospitality was apparent to all the visiting guests.

(b) The St. Clair County Medical Society Clinic of May 11 attracted 76 Doctors of Medicine to St. Clair Inn, St. Clair, Michigan. The guest speakers, Elmer

Quality carries on



C. Bartels, M.D., S. Allen Wilkinson, M.D., and Samuel F. Marshall are associated with the Lahey Clinic, Boston.

* * *

Voluntary Plans

To help popularize voluntary medical care programs, the Medical Society of the State of New York has prepared an exhibit to be circulated throughout that state. It tells of the advantages of prepayment group health plans to doctor and to patient. The exhibit is available to medical societies and any community organizations having meetings or a speaker on the subject of voluntary group medical care.

* * *

"The Resolutions Committee of the Republican State Central Committee has gone on record in favor of the adoption of a health insurance plan by voluntary method."—*Eastern Underwriter* (March 9, 1945).

* * *

Canada's Minister of National Health and Social Welfare, Brook Blaxton, recently stated that no form of state medicine would be introduced in Canada by the present government and that the present relationship between patient and doctor would be maintained. He stated that the object of the government was simply to make more money available for people to purchase more health services.

His statement further suggested that the health insurance legislation in Canada would begin to operate between July 1, 1946, and July 1, 1947.

Socio-Economic

The Ways and Means Committee of the U. S. House of Representatives may undertake a special study of social security, utilizing a staff of experts developed for the purpose. Report says that Leonard Calhoun will be in charge of this study. The investigation will be especially concerned with an analysis of the results of the program for the aged. The indications are that a considerable time will be spent on this analysis with a view to a complete rewriting of the law at some future date. Thus far nothing is said about an amendment of the law in relation to medical care.

* * *

John L. Lewis, in demanding a 10 cent royalty on every ton of soft coal mined, stated that the money (\$62,000,000 annually) would provide for his 400,000 union members "medical service, hospitalization, insurance, rehabilitation and economic protection."

* * *

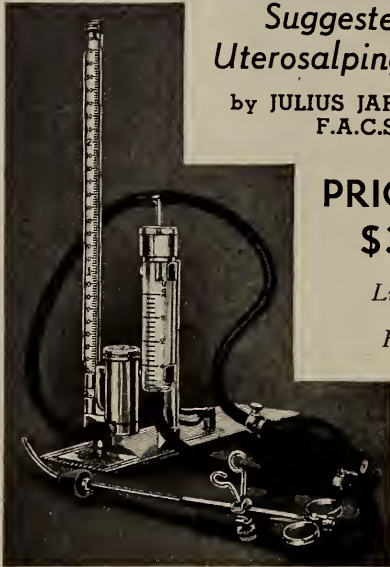
Nathan Sinai—Expert Witness.—Word comes from California that Nathan Sinai, Professor of Public Health Economics, University of Michigan, appeared before a committee considering Governor Warren's compulsory health insurance measure in California, as an expert witness and is reported as openly favoring the measure.

This may be something of a surprise as Professor Sinai was looked upon as one who viewed these matters purely objectively and not as a partisan. Many had come to follow *Public Health Economics*, published by the Michigan School of Public Health, as an im-

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partial source book for material in this field. The appearance of *Professor Sinai* before the Assembly Committee on Public Health held at the State Capitol at Sacramento, March 27, 1945, in favor of compulsory health insurance, naturally brings forth the thought that the real purpose of Professor Sinai and his school may be to promote compulsory health insurance.—*News Letter of Council on Medical Service and Public Relations, A.M.A., April 26, 1945.*

* * *

Monroe Shakespeare of Kalamazoo says: "In 1830 the total Federal tax budget was one dollar and a quarter per person.

"By 1860 the Federal taxes per person were only two dollars and even as late as 1910, they were still less than ten dollars per person.

"Under Woodrow Wilson (the Federal taxes per person were) \$25.58.

"Under Mr. Hoover, they dropped to \$23.28 and, on the average, for the 12 years with Mr. Franklin D. Roosevelt, they are \$101.44 per person or \$405.00 per family of four. Now they are about \$300.00 per person per year.

"When taxes only amount to 2 to 5 per cent, there is no need to care how they are collected or particularly how they are spent, but when they amount to four or six months of the average workman's income, he certainly is vitally interested."

* * *

The USPHS annual report, 1944, contains the following recommendations for a broad health program: (a) a hospital system adequate for the provision of complete medical service for all; (b) augmented research in the health and medical services; (c) a national health program.

The recommendation for a national health program stresses the wisdom of considering grants-in-aid from the federal government to areas which are unable to attract physicians and support health facilities; also grants-in-aid for the construction and operation of clinics and diagnostic centers partially to relieve the costs of medical care; and social insurance to spread the cost of medical care and to compensate employees for wages lost while ill.

* * *

Survey of Michigan Hospitals—The work of collecting data from the state's 800 hospitals and other nursing institutions is rapidly being completed, according to the Michigan State Hospital Survey Committee, of which Dr. Eugene B. Elliott, State Superintendent of Public Instruction, is chairman, and A. S. Brunk, M.D., President of the Michigan State Medical Society, is a member of the executive committee.

Nearly a hundred field workers, including hospital administrators, Blue Cross representatives, public health personnel, and nurses, volunteered their services in calling for the schedules of information, giving whatever assistance was needed in completing them, and checking the accuracy of the responses.

The information obtained is now being tabulated by the staff of the Commission on Hospital Care, of which

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A. C. Bachmeyer, M.D., Director of the University of Chicago Clinics and Associate Dean of the Division of Biological Sciences of the University of Chicago, is director of study.

The Michigan study has more than state-wide significance as it is serving as an example to other states, many of which are beginning to take stock of their hospital facilities.

* * *

"Regimentation Rampant" is the subject of a speech given by Senator E. H. Moore of Oklahoma from which the following is quoted: "An assault upon the insurance business and its sixty-odd million policyholders by the centralized New Deal Government has now been assured by a four-judge decision of the Supreme Court of the United States, in the case of United States against South-Eastern Underwriters Association, decided in 1944. It was there held that insurance transactions constitute commerce among the several states, so as to make them subject to Federal regulation under the commerce clause of the Federal Constitution and subject to the provisions of the Federal anti-trust laws. Thus a 75-year precedent that insurance transactions were intrastate in character and subject to the regulations of the particular states in which such transactions were carried on was reversed and the door opened to another avenue of regimentation for the New Dealers.

"This is the first time in history that a minority of the Supreme Court justices has reversed an important

precedent. It is the first time that a minority has assumed the responsibility of ruling on a question of constitutionality. Under the rules of the Supreme Court, four out of the nine Justices may render a decision, but in all the history of the Court the Justices have refrained from exercising that prerogative on the theory that it was improper for a minority to act on questions of such importance.

"The opinion was written by Justice Douglas and concurred in by Justices Black, Murphy, and Rutledge. It is now perfectly apparent that the insurance departments of the 48 states are to be rendered powerless and the life and fire insurance business and the millions of policyholders are to be regulated by the New Deal bureaucracy.

"For a long time it has been evident that there was a desire on the part of the New Dealers to bring the insurance business under the domination of the Federal Government in order that the control of the large funds involved might be put at the disposal of the bureaucracy. The opening of this latest avenue of the destruction of state rights, in my opinion, portends the most far-reaching step in all of the history of the New Deal."

* * *

Miscellaneous

"Sulfadiazine in Malaria" is the title of an article which appeared in JAMA of May 5, written by L. T. Coggeshall, M.D., Ann Arbor, Michigan, in co-operation



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* * *

The House of Delegates, California Medical Association, proposes to circulate to all AMA delegates two recently adopted resolutions regarding the work of the American Medical Association. One would require every public statement by any officer, council or bureau of the Association to be submitted to the Council on Medical Service and Public Relations previous to release. The other would prevent all employees of the Association from receiving any income except that received from the Association.

* * *

Gasoline Rations.—To avoid delay and inconvenience resulting from gasoline rations running out, your local board should be notified ONE MONTH before the "C" coupons you hold are likely to be used up. If this is done, there will be ample time for processing applications for supplemental or renewal applications.

* * *

The new Michigan Intangible Tax law imposes a levy of 3 per cent (instead of 6 per cent) on the income of all revenue-producing securities; \$1 per \$1,000 (instead of \$2) on the face of non-income-producing securities, and 40 cents per \$1,000 (instead of \$1) on bank deposits. Banks will pay the last charge. Individual taxpayers will be exempt from paying the first \$20 of tax on the other two items.

The courts will be asked to determine if the new intangibles tax on investments in Michigan corporations is constitutional.

Invitations for samples and information are being featured in many advertisements appearing in the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

May we invite the members' attention to these offerings and urge them to take advantage of the samples and information offered by their friends, the advertisers.

Chiropractors are getting more ambitious. Several identical bills in Congress (S. 178 and HB 610) would amend the Compensation Act for Employees of the United States to include not only Doctors of Medicine and osteopaths but "chiropractic practitioners licensed by state law." The chiropractors presented their arguments before the Senate Committee on Education and Labor on May 16.

* * *

State Board Examinations in Michigan

The complete examination of the Michigan State Board of Registration in Medicine will be conducted in the Auditorium of the College of Medicine, Wayne University, Detroit, Michigan, on Tuesday, Wednesday, and Thursday, June 26, 27, and 28, 1945. Fees and ap-

Applications should be filed in the State Office thirty days prior to the examination.

American Board of Obstetrics and Gynecology, Inc.

The general oral and pathology examinations (Part II) for all candidates will be conducted at Atlantic City, New Jersey, by the entire Board from Wednesday, June 13, through Tuesday, June 19, 1945. The Hotel Shelburne in Atlantic City will be headquarters for the Board. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the hotel.

Promotions

The Surgeon General announces the following promotions from Major to Lieutenant Colonel:

Harold Mark Dana, M.C., West Detroit
William Benjamin Davis, M.C., Detroit
Albert DeGroat, Detroit
Adam James French, M.C., Ann Arbor
Moses Michael Frohlick, M.C., Ann Arbor
Algot Reginald Nelson, Grand Rapids.
Clarence William Reuter, M.C., Bay City
Harry Albert Towsley, Ann Arbor
Herbert Charles Wallace, M.C., Saginaw
Charles Stewart Wilson, Detroit

PNEUMOCOCCUS TYPE III MENINGITIS COMPLICATING DIABETES MELLITUS

(Continued from Page 604)

given intravenously. The next eight days sulfadiazine was given orally grams II every four hours, and the following five days sulfadiazine grams I every six hours.

Penicillin was given intramuscularly every three hours for a period of fourteen days. Intrathecal doses of penicillin were also administered as follows: 2/25/44—25,000 units; 2/26/44—40,000 units; 2/27/44—12,500 units; 2/28/44—20,000 units; and 3/8/44—25,000 units.

The patient was discharged from the hospital on March 15, 1944, and has remained well. On May 16, 1944, the patient was discharged from the clinic with a healed mastoid incision, a dry auditory canal, and intact drum. He is still under treatment for diabetes and syphilis.

Comment: Pneumococcus type III meningitis complicating diabetes offers a grave prognosis. Recovery of this patient was due to eradication of the primary focus, control of the diabetes and simultaneous administration of sulfadiazine and penicillin. We were unable to determine whether one or the combination of the therapeutic drugs were responsible for the favorable outcome. It is our feeling that penicillin helped considerably in controlling the spread of the infection and in the recovery of this patient.

JUNE, 1945



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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

A TEXTBOOK ON PATHOLOGY OF LABOR. THE PUERPERIUM AND THE NEWBORN. By Charles O. McCormick, A.B., M.D., F.A.C.S.; Clinical Professor of Obstetrics, Indiana University School of Medicine; Consulting Obstetrician to William H. Coleman Hospital for Women, Indianapolis City Hospital, and Sunny Side Sanitarium. With 191 Illustrations, including ten in color. St. Louis: The C. V. Mosby Company, 1944. Price \$7.50.

This volume is the outgrowth of the author's lectures to senior medical students over a period of twenty-five years, with extra attention to pelvimetry, and abnormal presentations, postpartum hemorrhage, use of forceps, version and cesarean section. The text is largely in outline, well illustrated, and the various steps of procedure related in proper rotation. Puerperal sterilization and proper technique to prevent infection is profusely given. Caudal anesthesia is described, listing the technique, advantages and disadvantages. This is 399 pages of condensed information that will be valuable to doctors in their efforts to reduce maternal and infant mortality.

HAROFÉ' HAIVRI, the Hebrew Medical Journal, Volume II, 1944, The Seventeenth Year.

The first half of this magazine contains various articles in English, and the last half the same articles in Hebrew. Sketches of men who have won the Nobel prize in medicine, together with their photographs, include: Paul Ehrlich, Elie Metchnikoff, Robert Barany, Richard Willstaetter, Otto Meyerhof, Karl Landsteiner, Otto H. Warburg, Otto Loewi, and Joseph Erlanger.

IMPLICATIONS OF NUTRITION AND PUBLIC HEALTH IN THE POSTWAR PERIOD. Detroit: The Children's Fund of Michigan, 1945.

The proceedings of a Conference held at Detroit, Michigan, November 3, 1944, in the Horace H. Rackham Building under the sponsorship of the Research Laboratory of the Children's Fund of Michigan. It contains the offerings of twelve scientists interested in health problems, the advancement of public health, medical practice, and the science of nutrition. Available on application to selected professional people whose efforts are directed towards the objective mentioned.

PERIPHERAL NERVE INJURIES: By Webb Haymaker, Capt., M.C., A.U.S., Neuropathologist, The Army Institute of Pathology, Washington, D. C. (on leave of absence from the University of California, San Francisco and Berkeley); and Barnes Woodhall, Maj., M.C., A.U.S., Chief, Neurosurgical Section, Walter Reed General Hospital, Washington, D. C. (on leave of absence from Duke University, Durham, North Carolina). 227 pages with 225 illustrations. Philadelphia and London: W. B. Saunders Company, 1945. Price \$4.50.

The war effort has required many medical officers to recognize peripheral nerve injuries who have never been trained in that field. This book was planned to meet that situation. The text very clearly illustrates the procedure in making observations and tests to determine the place and extent of nerve injury. The illustrations are profuse, most of them diagrammatic. Procedures in exami-

nation, analysis of movements are given in detail. The third section takes up the more common injuries of plexuses and peripheral nerves. The book is mainly interested in diagnosis, not including treatment. The work is elementary in that it gives its information in simple and easily understood sketches, pictures and descriptions. It will be most valuable to all practitioners coming in contact with traumatic cases, and injuries.

CONSTITUTION AND DISEASE. Applied Constitutional Pathology. By Julius Bauer, M.D., Professor of Clinical Medicine, College of Medical Evangelists, Los Angeles; formerly Professor of Medicine, University of Vienna. Second Edition Revised and Enlarged. New York: Grune and Stratton. 1945. Price \$4.00.

Dr. Bauer has prepared a readable book upon the facts and philosophies of his lectures given to American students abroad. He has taken a vast number of facts and given them life. He applies them to constitutional variations, and the life and health of the patient. Up to now little attention has been given to the constitutional or genetic standpoint in both general and specialized practice of medicine, particularly in clinical endocrinology. This book is most interesting and thought-producing.

PENICILLIN AND OTHER ANTIBIOTIC AGENTS. By Wallace E. Herrell, M.D., M.S., F.A.C.P., Assistant Professor of Medicine, the Mayo Foundation, University of Minnesota; Consultant in Medicine, Mayo Clinic, Rochester, Minnesota. 348 pages with 45 illustrations. Philadelphia and London: W. B. Saunders Company, 1945. Price \$5.00.

The author has published the results of four years' work in the investigation and experimental study of penicillin since its first description. Its action against various types of infection is given at length, as well as the various plans of treatment, methods of application and dosages. The absorption diffusion and excretion are given. This is an extensive treatise on penicillin as it is now used, as well as short discussions of the other antibiotic agents, which this author was studying at the time penicillin was introduced. The knowledge of penicillin is concentrated in this volume for ready use.

YELLOW MAGIC. The Story of Penicillin. By J. D. Ratcliff. New York: Random House. 1945. Price \$2.00.

This pocket volume is an intimate story of the discovery, research, and development of penicillin to the wonder drug it has become. Its action and use in some otherwise fatal diseases, and its use in the venereal diseases is given. The book is intensely readable, and is distributed by the Schenley Laboratories.

CLINICAL ROENTGENOLOGY OF THE DIGESTIVE TRACT. By Maurice Feldman, M.D., Assistant Professor of Gastroenterology, University of Maryland; Assistant in Gastroenterology, Mercy Hospital; Consulting Roentgenologist, Sinai Hospital. Second Edition. Baltimore: The Williams & Wilkins Company. 1945. Price \$7.00.

An enormous amount of literature has been studied to produce this exhaustive treatise on roentgenology of the digestive tract. The author felt the need for such a book during his twenty-six years of practice in this field, and has written to supply the needs of the roentgenologist, but also of the gastrologist, the student and the general practitioner. The contents are classified under the esophagus, the stomach, the duodenum, etc., for twenty chapters. Every disease whose diagnosis may

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OBSTETRICS—Two-week Intensive Course, June 4 and October 8.

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be aided by the use of the x-ray is described, the frequency, pathology, differentiation, complications, age and sex are discussed, and then follows a list of references. The volume is complete so far as a book can be and contains 769 pages, with 550 illustrations. It would be invaluable in an x-ray laboratory, and most useful for the doctor who is meeting these cases and employing the roentgen diagnosis as an aid to his own studies.

THE EXAMINATION OF REFLEXES, A Simplification. By Robert Wartenberg, M.D. Foreword by Foster Kennedy, M.D. Chicago: The Year Book Publishers, Inc. 1945. Price \$2.50.

Literally hundreds of "reflexes" have been described, and the last third of a century has seen the minute and slightest variation from a standard reflex described and renamed. The mere learning of the names was impossible, and the interpretation almost as hopeless. The author undertook to solve the puzzle and has simplified the field, grouped the tests, and written a readable book on the subject. This is a must for the neurologist who no longer exists, also for the busy practitioner who studies his patient from a neurological aspect. 465 references are given at the end of the volume, in the order mentioned in the text.

BEDSIDE CLINICS of Francis D. Murphy, M.D., F.A.C.P. Professor and Head of the Department of Medicine of the Marquette University Medical School and Clinical Director of the Milwaukee County General Hospital and Emergency Unit. Volume I. Milwaukee: Marquette University Press. 1945.

This is the first volume of a new set of bedside clinics, and its object is to present to the physician and to the student a brief discussion of the approach in making the diagnosis and applying the treatment. The cases presented make up most of the text. First is a concise history from a paragraph to a page. Then a discussion bringing out many facts about the condition under discussion, its frequency, course and prognosis. Then follows a considerable discussion of the treatment. Frequently there follows a series of questions by students, and answers. The conditions discussed are all medical, and classified as Heart, Blood, Essential Hypertension, Metabolic Dis-

turbances, Nervous System, Lung, Abdomen, Kidney, Liver, etc., and drugs. The style is good and the presentation clear. It is a valuable set of Clinics.

MEDICAL GYNECOLOGY. By James C. Janney, M.D., F.A.C.S., Assistant Professor of Gynecology, Boston University School of Medicine, Boston, Massachusetts. 389 pages with 97 illustrations. Philadelphia and London: W. B. Saunders Company, 1945. Price \$5.00.

The author has limited the scope of this book to office gynecology, and has based it upon his twenty years of teaching experience. The arrangement is orderly, the first section devoted to history taking and the physical examination, also the grouping of the patient. Nearly half the book is devoted to discussion of the patient's complaints, the reasons and the treatment. Sexual maladjustments, frigidity and passion are carefully analyzed. The balance of the book studies the physical findings, their diagnosis and treatment, non-surgical. A section is devoted to tests and special examinations. Gynecological treatments such as rest, antiseptics, exercises, cauterization, coning, fulguration, vitamin therapy, chemotherapy, etc., are fully and clearly discussed. There is also a section on Socio-medical problems. The book is well conceived, and very useful.

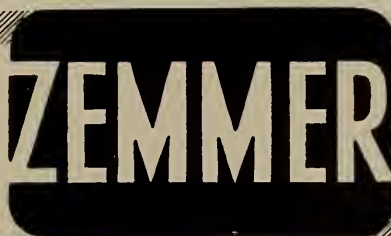
TRAUMA IN INTERNAL DISEASES, with Consideration of Experimental Pathology and Medicolegal Aspects. By Rudolf A. Stern, M.D., Assistant Attending Physician, City Hospital, New York City. Foreword by Francis Carter Wood, M.D., Director of Laboratories and Radiotherapy Department, St. Luke's Hospital, New York City. New York: Grune & Stratton, 1945. Price \$6.75.

This is a discussion of every imaginable disease that can or has been attributed to trauma. "There is no field of medicine that presents so many obscure phases, or in which it is so difficult to found sound opinion on a scientific basis as that of traumatically caused internal diseases." Opinions and findings must depend on the judgment of the physician, and many of these cases are court cases, where the doctor's judgment must be the determining factor. The book is a compilation of discussions, theories, and court findings, with hundreds

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of case records. References are given under various classifications such as diseases of the respiratory system, cardiovascular system, infectious diseases, diseases of metabolism, etc. This is a book of untold value to the doctor who has to appear in court on questionable cases.

PENICILLIN THERAPY, including Tyrothricin and other Antibiotic Therapy. By John A. Kolmer, M.S., M.D., Dr.Ph., Sc.D., LL.D., L.H.D., F.A.C.P., Professor of Medicine in the School of Medicine and the School of Dentistry, Temple University; Director of the Research Institute of Cutaneous Medicine; formerly Professor of Pathology and Bacteriology, Graduate School of Medicine, University of Pennsylvania. New York and London: D. Appleton-Century Company, 1945.

The literature on penicillin has become so voluminous that the author has prepared this monograph to make the knowledge useful to the medical and dental professions. The important literature has been reviewed and summarized. The production of penicillin is described, its purification, and preparation for use. This is not so important now that the drug is easily obtainable, but is important to an understanding of the therapy. The administration and dosage is given, and its use in many mentioned diseases. Each chapter is followed by a list of numerous references. This is one of the valuable books for the use of the student and the busy practitioner. It is not too long, and is definite in its recommendations.

POLL UNFAVORABLE TO SOCIALIZED MEDICINE

The recent poll conducted by the Chamber of Commerce and industrial leaders showed a vote of 2,346 against state or socialized medicine as compared with 76 favoring it. We are opposed to socialized medicine and believe that if it was generally understood the vote among industrial leaders would reflect the sentiment of the entire country. The fact is that there has been little demand from the people for socialized medicine. Most of the demand comes from a few officials at Washington. Before socialized medicine is dumped in the lap of the nation the majority of the people should ask for it. Who and what doctor a man has for himself or his family should continue to be a matter of his own personal choice. So far as we have been able to discover there is no demand to change the present system. What the country could use more of perhaps is good hospitals but to date it doesn't need any tinkering by experts at Washington with the Medical services and its family doctors.—*Tampa Record*. (Quoted by Florida Medical Association, December, 1944)

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DOSAGE: 1 or 2 teaspoonfuls in a glass of water, milk; or fruit juice once or twice daily, followed immediately by another glass of liquid. It may also be placed on the tongue and washed down, or it may be eaten with other foods such as cereals. Ample fluid intake is advisable to assure maximum bulk formation.

*Gray, H. and Tainter, M. L.; *Am. J. Digest Dis.* 8:130, 1941

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WAGNER SOCIAL SECURITY BILL OF 1945

Early information concerning the new social security bill (S. 1050) introduced by Senator Robert F. Wagner, on Thursday, May 24, 1945, indicates that the measure differs from the original Wagner-Murray-Dingell Bill in only three major respects:

1. A hospital construction program is included.
2. Tax rates for employers are 4 per cent, for employees 4 per cent and for self-employed 5 per cent, applied to wages up to \$3,600.
3. The medical care provisions have been modified in an attempt to overcome the charge of "socialized medicine." Dental and nursing services included.

The new bill contains ten sections, as follows:

Section 1. Short title is: *Social Security Amendments of 1945*.

Sections 2 and 3. Provide for grants and loans for hospital construction and other health facilities.

Section 4. Provides for federal grants to states for expansion of public health services.

Section 5. Provides for federal grants to states for maternal and child health and welfare services.

Section 6. Provides for federal grants to states for an increased comprehensive and public assistance program.

Sections 7 and 8. Provide for continuation of federal operation of the United States Unemployment Services.

Section 9. Establishes a national social insurance system in eight parts:

Part A. Provides for insurance for medical care costs.

Part B. Establishes unemployment insurance benefits and *temporary disability benefits*—same basis as original bill.

Part C. Establishes retirement, survivors and *total disability benefits*—same basis as original bill.

Part D. Establishes national social insurance trust fund.

Part E. Establishes credit based on \$160.00 wages for each month of military service.

Part F. Extends coverage to about 15 million additional persons.

Part G. Establishes contribution rates—see above.

Part H. General provisions.

Section 10. Definitions.

Members of the Michigan State Medical Society are urged to write to their Congressman or to one of the U. S. Senators from Michigan, asking

for a copy of S. 1050 (or H. R. 3293, the companion Bill in the House).

* * *

AFFIDAVIT TO ESTABLISH SERVICE CONNECTED DISABILITIES

The MSMS Committee on Medical Veterans' Readjustment Program met on May 16 with Governor Harry F. Kelly, Colonel Philip C. Pack and Major A. D. Alguire of the Office of Veterans' Affairs, State of Michigan. The ensuing discussion on the readjustment program for doctors of medicine separated from military service, on emergency hospitalization of veterans, and on booklets of information for returning medical veterans indicated the great scope of the Committee's work.

The need by veterans of affidavits to establish service-connected disabilities was presented. Major Alguire stated that the livelihood for the rest of the veteran's life may depend upon an affidavit.

The medical men present urged that the Office of Veterans' Affairs develop a short model affidavit form, as simple as possible. Such a certificate has been developed and is printed below. The form is a model of compactness and yet contains all the necessary information.

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..... and upon physical examination elicited the following objective clinical findings and symptomatology:

.....

Is the above information furnished from memory or your office records?

If the information is taken from office records a verbatim transcript of such record with dates should be furnished in the space provided next below.

.....

Date, M.D.
(Signature of Physician)

(Address)

Personally subscribed and sworn to before me, a Notary Public, this day of, 19....

(Turn to Page 648)



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CIVILIAN MEDICAL TREATMENT OF SOLDIERS

In order to receive civilian medical treatment at Government expense, military personnel must be on *authorized* leave, pass or furlough in an area in which Government facilities for such treatment are not available within a reasonable distance.

The physician or hospital rendering treatment must notify *without delay*, by wire or letter, the Commanding General, Sixth Service Command, 20 North Wacker Drive, Chicago 6, Illinois, attention the Surgeon. The notification must give the name, rank, organization and station of the person treated, the diagnosis and the estimated duration of treatment.

Treatment will be limited to conditions of an acute nature, and no surgical procedures except in emergency will be accomplished without the approval of this headquarters. Treatment of elective medical or surgical conditions is not authorized, and laboratory procedures considered non-essential to the diagnosis and treatment are not compensable.

Private rooms and special nurses will not be provided without authorization from this headquarters.

On completion of treatment, an *itemized* statement will be mailed to this headquarters covering all services rendered.

* * *

MEDICAL SACRIFICES IN WAR

During this struggle the medical profession has contributed over 50,000 of their numbers to the armed forces. These highly skilled men are capable of bringing years of experience wherever needed. They are of all ages, from cities and villages, specialists and general practitioners working together for the common cause.

As a result, 97 out of every 100 soldiers wounded in battle were saved. In addition, miracles of rehabilitation have been performed. The death rate from illness was reduced more than 95 per cent over what it was in the last war. This record reflects the high caliber of the medics who are responsible for the welfare of our fighting men. Those who have lost their dear ones can be assured that the best of care was always available.

By May of 1945, over 438 physicians had died while serving their country. Of these, 130 were killed in actual combat. This figure represents only a certain proportion of the total because of the natural delay in releasing information of this type. This does not include the litter bearers who go unarmed into the thick of battle in search of the wounded nor the ambulance drivers, nurses, technicians, and dentists. These men and women have faced risks so that others might live. They can be found in foxholes, landing barges, and ships at sea and in the air.

Others have subjected themselves to the dangers of research. This group includes those who studied tropical

diseases and the effects of various machines on the human body. One flight surgeon, who was testing a certain oxygen container for high altitude jumps, descended in a parachute from an altitude of nearly 8 miles (40,200 feet), and set an American record. Another, who tried a similar experiment, was killed in the attempt.—*Chicago Tribune*, June 3, 1945.

GIFT TO WAYNE UNIVERSITY

Clark D. Brooks, M.D., has made a grant to the College which will furnish tuition to a Negro student enrolled in the College of Medicine.

CROWDED HOSPITAL SITUATION

At the final session of the State Legislature, June 7, 1945, the Senate launched an investigation into the crowded hospital situation. Senator Charles S. Bondy of Detroit complained that patients holding hospital service contracts, commonly called hospital insurance, were crowding hospitals for treatment of relatively minor ailments.

The crowding is so bad, he said, that persons vitally in need of hospital treatment sometimes could not be received.

Bondy said the recent death of his mother was in part due to inability to find hospital accommodations for her when she was stricken with a heart ailment three weeks ago.

At the same time hospitals were filled, he said, with patients receiving treatment for less vital illness. Many of these would have been treated at home, he said, except they could not collect hospital service benefits unless they became hospital patients.

WAYNE MEDICAL SCHOOL HONORS OLD GRADUATES

Life memberships in the Wayne University College of Medicine Alumni Association were presented to 20 medical men at the annual dinner of the association held Wednesday, May 16, 1945, at the Statler. All were graduated from the school fifty or more years ago.

The oldest graduate honored was Dr. John A. Wessenger, for the past 30 years health officer for the city of Ann Arbor. Dr. Wessenger, who despite his eighty-five years is still in active practice, received his diploma in 1882.

Life memberships were also presented to Dr. Walter J. Cree, for many years historian of the Wayne County Medical Society, who was graduated in 1883; Dr. Alfred N. Shotwell, of Mt. Clemens, 1884; Dr. Mortimer E. Roberts, of Grand Rapids, 1889; Dr. William J. O'Reilly, of Saginaw, 1890; Dr. Christian Storz, of Toledo and Dr. Adolphus J. W. Nixon, of Highland Park, both of the class of 1891; Dr. N. T. Shaw, of Pontiac, 1892; Dr. D. J. McColl, of Port Huron and Dr. William H. Hoppenrath, of Elwood, Indiana, both graduated in 1893.

Honored members of the class of 1894 included Dr. George Alexander, of Pontiac; Dr. Henri Belanger, of

(Continued on Page 658)

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* Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60



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JULY, 1945.

Say you saw it in the *Journal of the Michigan State Medical Society*

It's The Law, Doctor!

Juris ignorantia est, cum jus nostrum ignoramus—Old Maxim

NOTES ON COURT DECISIONS, STATUTES AND OTHER AUTHORITIES

Hospital Records—Admissibility in Evidence

J. JOSEPH HERBERT, LL.B., General Counsel MSMS
Manistique, Michigan

Prior to 1935, in Michigan as in most American jurisdictions, the admissibility of business records in evidence was hedged about with a great many archaic rules and decisions. The common law on which our practice was based, required that the books to be admissible be of "original entry"; that there be testimony of one having personal knowledge of the facts represented by the entries; that the use of the records be limited to proof of debits and credits in trade, and in addition, had a multitude of other technical restrictions and qualifications. Indeed, as was said by the appellate court of New York, "Under modern conditions, the limitations upon the right to use books of account, memoranda or records made in the regular course of business, often resulted in a denial of justice, and usually in annoyance, expense and waste of time and energy. A rule of evidence that was practical a century ago had become obsolete. The situation was appreciated and attention was called to it by the courts and text writers." *JOHNSON v. LUTZ*, 253 N. Y. 124.

As a consequence of this situation, the Legal Research Committee of the Commonwealth Fund in 1927 published a report proposing a reform in the proof of business transactions to harmonize with current business practice. The report, based on extensive research, pointed out the confusion existing in decisions in different jurisdictions. It explained and illustrated the great need for a more practical, workable and uniform rule, adapted to modern business conditions and practices. At the close of its report, it proposed a statute to be enacted in all jurisdictions, to afford a more workable rule of evidence in the proof of business transactions.

Maryland, New York and Rhode Island promptly followed the suggestion, and in 1935 the Michigan legislature enacted the model law. The new act extended the old rule to include books and records kept in a "profession, occupation and calling of every kind," and thus, for the first time in Michigan, hospital records were made specifically admissible in the same manner as books of business. Hospital records may be received in evidence, regardless of whether they constitute an original entry or whether the entrant is available to testify to its correctness. If it can be shown that the hospital record was made at the time or shortly after the happening of "any act, occurrence or event" in regular course, when it was the regular course of the hospital to make such record, it is considered sufficiently authenticated to be admitted in evidence.

In the first case involving a hospital record to come before our supreme court after the adoption of the model act, the hospital chart containing the following was held admissible, per se:

"Remarks: 7:50. Admitted to the hospital, carried in. Bleeding from mouth, pulse very weak. Color cyanotic. 8:00. Doctors Vaughan and Hudnutt here. No pulse. Respiration ceased. Medicine: Caffeine amp. 1. Admitted 7:50 p.m. Discharged 8:00 p.m. Exp."

The Court said: "We hold that the hospital records in the instant case came within the purview of the act and it was error on part of the trial court to exclude them." *GILE v. HUDNUTT*, 279 Mich. 358.

The act, nevertheless, has its limitations. For example, hospital records may not be used to show that a person had practiced medicine without a license, although a hospital chart made in regular course by a nurse in the admitting room indicated medical practice. The decision rests on the well-recognized rule that one accused of crime has a right to be confronted with the witness against him, and records may not be substituted. *PEOPLE v. LEWIS*, 294 Mich. 684.

Another limitation in the use of hospital records, is that they may be used solely to prove facts, transactions, occurrences or events incident to treatment. The patient's narrative or history of his case or his account of the manner in which his injury occurred prior to admission to the hospital, are regarded as pure hearsay and the hospital record may not be used to prove such matter. In the case of *SADJAK v. PARKER-WOLVERINE Co.*, 281 Mich. 84, the sole question presented was whether the plaintiff met the burden of proof to establish that her husband sustained a compensable injury that arose out of and in the course of his employment. The decedent had suffered a double lineal fracture of the skull in the right frontal portions. He was taken to a hospital, where he remained for five days, was later removed to his home, taken to another hospital, and died on the following day. Hospital records were offered in evidence and contained portions which stated that the decedent fell from a ladder. There was no other proof as to the manner in which the patient had been injured. The court said:

"What decedent told the hospital authorities did not refer to any act, transaction, occurrence or event in the hospital treatment. The portion of the record thus objected to was pure hearsay and of no evidentiary force, and inadmissible."

(Continued on Page 757)



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Say you saw it in the Journal of the Michigan State Medical Society



Business Side of Medicine

MEDICAL INCOMES IN WARTIME

A Comparison of Income and Expense in 1939 and 1944

By HENRY C. BLACK and ALLISON E. SKAGGS

Battle Creek, Michigan

On previous occasions^{1,2}, we have reported our average findings of incomes and expenses in the various offices of the members of the Michigan State Medical Society, hoping to furnish figures which would be of value to those desiring to make comparisons with their own experience. Much has been said about the increases in business enjoyed (?) by the medical doctors in wartime and the careless talk which has distorted the thinking of physician and layman alike has prompted us again to present actual figures taken from records at our disposal.

A note of explanation might well be in order before presenting these figures in detail. In the first place our source of information is the M.D. for whom we work. Although we lost approximately 40 per cent of our clients to the Armed Services, we have more than replaced them with men generally older and with much better established practices. Also with the early recruiting of physicians from the smaller communities, the ratio of men in small towns to those in the larger cities has changed somewhat. In general, however, our figures are taken from the same localities, from the same type of practice and from the same sources as they were in our report of the 1939 figures² differing only in the fact that a small part of the increase in income shown in 1944 could be accounted for by the reduction in the number of sets of figures of the younger men, which comprised part of our earlier averages.

With thousands of physicians in the Armed Services, and with the high industrial employment, it is not surprising to find the average gross income up two or three times that of 1939. Of course, in individual cases, this increase varied more but the surprising thing to us has been that the increase was not greater. Obviously such an increase in volume never would have occurred had the Doctors not equipped themselves with adequate help, better office facilities, more efficient office routines, etcetera. The assistance Professional Management was able to furnish in this conversion to wartime medicine was one more proof of the importance of being currently informed as to the trends of practice, and being prepared to take immediate advantage of them. As a matter of fact, even before we entered the war many of our clients were urged to enlarge their quarters, duplicate their equipment and augment their staffs for an increase in volume.

One other observation should be brought out in this respect; namely, that in all our experience we found very little evidence of any increase in fees, except in

those cases where they were well below average before the emergency. There were very few cases where the law of supply and demand prompted short-sighted physicians to take advantage of the situation and, in general, the apparent increase in fees was that which necessarily resulted from the elimination of all unnecessary "frills." This seemed to be the only way to take care of many communities and not permit anyone to go without necessary medical care.

The following table is almost self-explanatory. The first two columns are the average income and expense figures for our medical doctors in 1939 and in 1944 respectively. The third column represents the 1944 percentage increase over 1939.

AVERAGE INCOMES AND EXPENSES
1939 and 1944

	1939	1944	Percentage of Increase
Business Done	\$12,406.91	\$30,229.74	143%
Cash Received	10,954.10	29,637.00	170%
Expenses:			
Rent	630.87	1,012.50	61%
Drugs & Supplies	1,166.51	2,500.00	114%
Salaries	1,115.75	3,221.00	190%
Car, including Depreciation	589.59	900.00	51%
All Other	1,313.75	1,156.50	165%
Total Expense	\$ 4,816.47	\$ 9,790.00	103%
Profit	6,137.63	19,847.00	223%
Income Tax	400.00	6,558.00	1539%
Net profit after Income Tax	5,737.63	13,289.00	132%

It might be well to discuss some of these increases in detail. For example, the principal reason for the increase in rent is not, as might first be imagined, an increase in rates paid, but rather results from the additional space required. Likewise, although the relative number of house calls per dollar of income dropped, there was almost as much, if not actually as much, driving as in 1939, *plus the repairs necessary* to keep older automobiles on the road. With few new cars available, even to the doctors, car expenses as a result increased 51 per cent.

Drugs and Supplies did not increase quite as much as the increase in volume of business, and this can be explained by pointing out that previous averages included the figures from many doctors in rural communities who dispensed more than their city colleagues. Also, the general trend, even in larger communities, was toward more prescriptions and less dispensing.

Salaries (the only item which went up more than the volume) increased both in the rate paid and in the number employed. Naturally the larger volume of

(Continued on Page 656)



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Views of the left hand of a female, aged 52 years, illustrating an advanced rheumatoid arthritis; duration of disease, 10 years; occupation, typist.

In addition to the marked deformities present, the subnutritional state of the tissues is well shown by the dry, shiny parchment-like skin with almost complete absence of the palmar lines. The terminal phalanges show a reddish discoloration of the ulnar surface.

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Certain of the joints are swollen and discolored, a result of early periarticular inflammation and then secondary growth of fibrous tissue. General involvement: feet, ankles, knees and elbows. X-ray shows the following advanced rheumatoid changes: marked narrowing of all the joint spaces, punched out areas of bony destruction, loss of articular surfaces of the metacarpal phalangeal joints and some lipping and osteophytes demonstrated best in the first finger.



MEDICAL INCOMES IN WARTIME

(Continued on Page 752)

work necessitated having more, and if possible, better assistants, nurses, laboratory technicians, etc. Also, without being held down by wage ceilings, except where more than eight persons were employed, and with wage rate competition in war plants and government agencies, payroll rates increased an average of 10 to 15 per cent per year from 1941 to 1944. We are now conducting a careful study of these increases and a report may soon be made available in a subsequent issue of THE JOURNAL of the Michigan State Medical Society.

The title, "All Other Expenses," includes such items as Depreciation of Instruments and Equipment, which remained about the same; Conventions, Dues and Journals, which remained almost constant; Laundry and Miscellaneous Office Expenses, which rose proportionately; Fees to others, which increased proportionately, and Social Security Taxes, which paralleled salary changes.

The most outstanding increase, of course, is in the Federal Income Tax, which increased over 1500 per cent! This was due in part to the higher incomes, but primarily to the several changes in the tax rate itself. Thus, while the net profit from profession (before taxes) went up more than the gross profit, because savings could be made in efficient management, the net profit *after taxes* increased much less, and although most doctors were better off financially, about half of the additional income was absorbed by the Income Tax. In a few cases, where the incomes were very high in 1939, *all or more of the increase in 1944 went for income tax!*

We have made no effort to analyze living expenses, life insurance premiums, et cetera. Living expenses were up and, in the average medical doctor's experience, much more so than the figures generally presented by government agencies. Due to many of our clients' using cash surpluses to pre-pay life insurance premiums (which may be discussed in another article) the total paid out for life insurance does not present a true picture of the annual costs, and was therefore not included.

Lest anyone confuse our averages with the income of the average physician, it should again be pointed out that these doctors for whom we work have much better than average incomes and of necessity, if PM service is of value to them, enjoy a higher degree of the fruits of their labors than does the average physician. Also these observations are based on dollar incomes; if the physical energy of these men is considered, most of them aged many years in the first three years after Pearl Harbor. Where we have as yet to experience a death among our well over one hundred former clients serving in the Armed Services, we have lost several on the home front through death, and many others have been temporarily disabled in the same period, many of whom would have survived in normal times. If the incomes could have been compared on a "per hour" basis, the results might have been surprising.

To summarize: our doctors did 243 per cent of their 1939 volume in 1944; collected 270 per cent of their 1939 collections. With the exception of salaries, their costs

increased less than did the volume of their business, but income taxes absorbed nearly half of the additional profits.

2004 Central Tower
Battle Creek, Michigan

REFERENCES

1. Black and Skaggs: The cost of practicing medicine. J. Michigan M. S., (August) 1937.
2. Black and Skaggs: A study of incomes and expenses for 1939. J. Michigan M. S., (Sept.) 1940.

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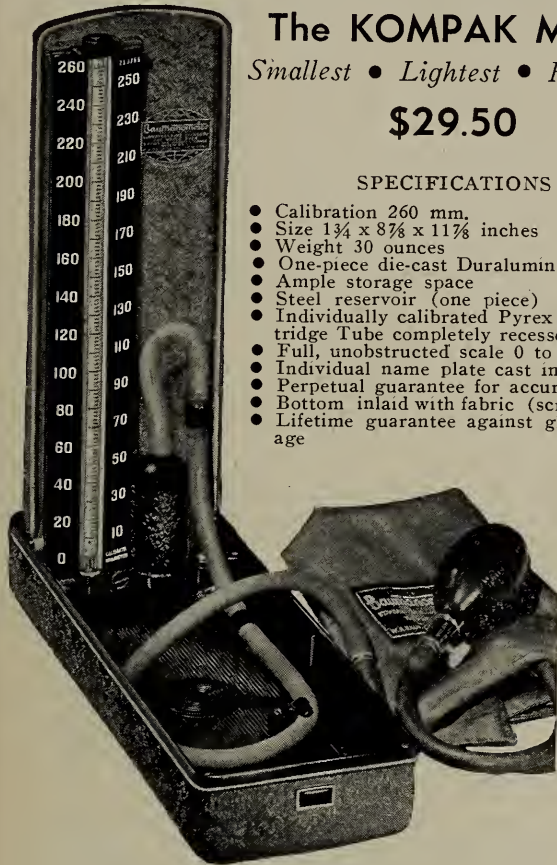
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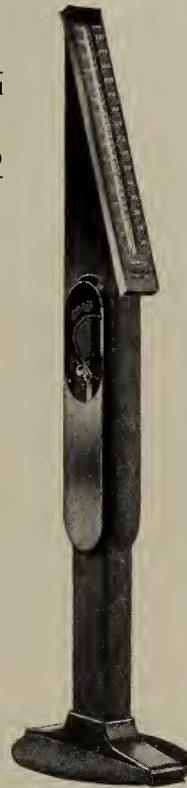
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War Medicine

SURGEON GENERAL OUTLINES PERSONNEL RELEASE POLICY

Substantial releases of Army Medical Department personnel will not take place before the latter part of this year, Surgeon General Norman T. Kirk said in announcing a policy on discharges in conformity with War Department procedures. This is due to the fact that the peak of the Medical Department's activities will not be reached until fall.

In formulating the policy, consideration was given to civilian needs for professional medical, dental and veterinary care without weakening military needs. Other factors considered were the length of time necessary for personnel to complete their work in the Mediterranean and European theaters and return to the United States; replacement of Medical Department personnel in active theaters by those who have not had overseas duty; necessity for the maintenance of a high standard of medical care; the heavy load of patients in the United States; evacuation of the sick and wounded from Europe in the next ninety days and continuing medical service in the Pacific.

The policy applies with equal effect to Army medical officers assigned to the Veterans' Administration and other agencies.

It reads:

Medical Corps

(a) Officers whose services are essential to military necessity will not be separated from the service.

(b) Officers above 50 years of age whose specialist qualifications are not needed within the Army will receive a high preferential priority for release from active duty.

(c) Adjusted Service Ratings will be utilized as a definite guide to determining those who are to be separated.

Medical Department Accomplishments

During the past three years, the Medical Department has maintained a record of less than one death from disease per 1,000 men per year. During the World War, 19 out of every 1,000 men died each year from disease. During the Spanish-American War we lost 26 out of every 1,000 per year, and in the Civil War, 65 out of every 1,000 men died each year from disease.

In all, during this war, 12,000 men died from disease from December 7, 1941, to May 1, 1945. In World War I, 62,670 men died from disease; in the Spanish-American War, 3,500 died from disease, and in the Civil War, 336,216 men of the Union and Confederate armies died from disease.

The peak of the Medical Department's activities will not be reached until the fall of 1945. At present, wounded and sick are being returned to this country from all theaters at the rate of 44,000 a month. This evacuation will continue until all of the patients in the European and Mediterranean theaters are removed, which will require ninety days.

A release from the Michigan Department of Health for May 21, 1945, reports that more than two million dollars have been spent in Michigan during the two years of this EMIC program for the care of over 32,000 wives and new babies of servicemen. There have been applications for 28,639 wives and 4,061 infant care. The old canard that the EMIC "pays for all medical care for maternity cases from the beginning of pregnancy, through the postpartum examination which is given about six weeks after the baby is born," is still released to the public press. We understand that is true, but the amount is very definitely limited to five pre-natal attentions and one postnatal. As we understand adequate maternal health programs, that is not considered enough, but the doctor who cares for these patients is estopped from charging for more than that minimum.

Dr. Martha Eliot, associate chief of the Children's Bureau, reports that more than 750,000 maternity cases have been cared for by the Bureau, and that the federal government is now paying for one birth out of six.

* * *

The war in which we are engaged has produced many seemingly unsurmountable problems, problems without precedent in the development of new weapons, new methods of training, and new tactics. But none of these problems has been more difficult than the problems faced by our Medical Department in caring for the largest American Army in history, fighting in virtually all parts of the world. And yet, no Army at any time in history has achieved a record of recovery from wounds and freedom from disease comparable to that of the American Army in this war.

* * *

The Medical Department, its doctors, its nurses, its corpsmen, has saved the lives of ninety-seven out of every 100 men wounded in battle who reach a hospital, compared with ninety-two in the World War. Seventy out of every 100 wounded overseas were returned to duty, and twenty-seven evacuated to this country.

WAYNE MEDICAL SCHOOL HONORS OLD GRADUATES

(Continued from Page 648)

River Rouge; Dr. Alexander Thomson, of Detroit; and Dr. Orlando A. Tooker, of Lansing.

The class of 1895 was represented by Dr. C. W. Barrett, now of Chicago; Dr. Adelbert Edwards, of Detroit; Dr. Thomas E. DeGurse, of Marine City; Dr. C. D. Monroe and Dr. George E. Winter, both of Jackson; and Dr. Burt R. Shurly, member of the Detroit Board of Education.

Main speaker at the dinner meeting was Dr. C. A. Mills, professor of experimental medicine at the University of Cincinnati, who spoke on "Climatic Imprint on Man."

The JOURNAL

of the Michigan State Medical Society

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The Pathology of Rickettsial Disease

By Robert A. Moore, M.D.
St. Louis, Missouri



*Professor of Pathology,
Washington University
School of Medicine, St.
Louis; Pathologist to the
Barnes Hospital, St. Louis.*

American physicians in the past have had little practical need for information on rickettsial diseases. In the 1930's an increasing number of patients with Rocky Mountain spotted fever was observed in the Midwestern and Eastern states. American troops are now stationed in parts of the world where louse-borne and flea-borne typhus and scrub typhus or tsutsugamushi fever are endemic or epidemic.

The essential anatomic lesion in rickettsial disease is an inflammation of vascular walls with secondary inflammation in certain viscera and tissues. The clinical signs and symptoms are directly related to the pathologic changes.

■ Not so many years have passed since the attitude of the practicing physician in the United States toward the rickettsial diseases could be summarized as "oh, the rickettsia are some strange, small parasites, like bacteria. I learned about them in school, but they are of little importance to me now, because the rickettsial diseases, typhus and spotted fever, are not prevalent in the continental United States except in Montana." Perhaps this was correct in 1910, but it

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is not true in 1944. Let us see then how and why there has been and must be a change in interest and viewpoint.

The Scope of Rickettsial Diseases

The rickettsiae were first described by Howard Taylor Ricketts, of the University of Chicago, in 1909, and were so named by daRocha Lima in 1916. During and after World War I epidemic typhus was a major problem in the Balkans and in Eastern Europe. Our basic knowledge of typhus dates from that period. Shortly after the war, one of the most distinguished of American scientists, Dr. R. E. Dyer, of the United States Public Health Service, interested himself in Rocky Mountain spotted fever and, with many associates, notably Cox and Topping, has contributed much to the subject.

It is customary to say that there are three basic types of rickettsial disease—the typhus fever group, the spotted fever group, and the group seen in Japan and the Southwest Pacific usually known as tsutsugamushi fever. The reason for this classification is evident if we examine the results of the Weil-Felix reaction. Each of this group gives a so-called "main" agglutination, with a different strain of bacillus proteus.

	"Main" Agglutination
Typhus fever	OX19
Spotted fever	OX2
S. W. Pacific group.....	OXX

This classification might be satisfactory for superficial study, but unfortunately there are several diseases which do not fit into the scheme, and there is some confusion because of false interpretation of earlier investigations. For example, Sao Paulo "typhus" shows morphologic and immunologic characteristics suggesting that

it is a spotted fever but the "main" agglutination is with OX19, the variety characteristic of typhus.

From the standpoint of the bacteriologist, the best classification is one based on the distinct species and varieties known to cause disease (Pinkerton).

Genus *Rickettsia*

- Species *proWaseki*
- Variety *proWaseki* (louse-borne typhus)
- Variety *mooseri* (murine typhus)
- Species *tsutsugamushi* (tsutsugamushi fever)
- Species *ruminatum* (heart water fever)
- Species *pediculi* (? trench fever)
- Species *burneti* (Q fever)

Genus *Dermacentroxenus*

- Species *rickettsi* (spotted fever)

One is apt to become lost in the maze of nomenclature unless the many local synonyms are borne in mind. For the five principal rickettsial diseases they are as follows:

1. Louse-borne typhus—Epidemic typhus, and classical typhus
2. Murine typhus—Endemic typhus, flea-borne typhus, tabardillo, urban typhus of Malaya, Brill's disease, shop typhus of Malaya, ship typhus of Toulon, and South African typhus.
3. Rocky Mountain spotted fever—Sao Paulo typhus, and boutonnose fever of the Mediterranean.
4. Tsutsugamushi fever—Scrub typhus, rural typhus, Sumatran mite fever, Japanese River fever, pseudo-typhus, and coastal fever of Australia.
5. Q fever—Queensland fever, Australian Q fever, and Nine-Mile fever.

In addition to these well-recognized diseases, there are several others not yet sufficiently well studied to define; notably the rickettsioses of India (Topping, Heilig and Naidu).

Related in the methods of transmission, but probably not rickettsioses, are Colorado tick fever, South African tick fever, Kenya typhus, and Colombian spotted fever. At least the sera of patients with these conditions do not contain agglutinins against any strain of proteus OX.

The Prevalence of Rickettsial Diseases

Regardless of cause—increasing recognition, or absolute increase—it must be acknowledged that many more examples of rickettsial disease were seen in the United States during the fourth decade of the 20th century than in the second and third decades. Let us for a moment examine the statistics for a few selected states of the Southern United States (Table I).

For eleven southern states the increase in sixteen years from 1922 to 1938 has been 150 fold, as shown in Table II, taken from the paper by Meleney.

TABLE I. ENDEMIC TYPHUS CASES REPORTED

State	1926	1931	1935	1939
Georgia	17	290	489	1,103
Louisiana	—	1	20	115
Texas	20	43	265	583
Alabama	47	80	294	471

Of even greater interest to you is the appearance of typhus in so-called northern states, and of spotted fever in the eastern states, during the

TABLE II. CASES OF ENDEMIC TYPHUS

1922	15
1926	112
1930	375
1934	1,265
1936	1,711
1938	2,272

last twenty years. In Table III I have taken the figures from the quarterly morbidity tables of the United States Public Health Service for the year 1943 and tabulated the cases reported from the nine geographic divisions of this country.

TABLE III. CASES REPORTED IN UNITED STATES
1943

District	Spotted Fever	Typhus Fever
New England	2	4
Middle Atlantic	43	22
East North Central	40	3
West North Central	40	3
West North Central	15	3
South Atlantic	172	1943
East South Central	34	810
West South Central	14	1700
Mountain	97	2
Pacific	21	30

It is perhaps surprising that there were more examples of spotted fever in the South Atlantic part of this country than in the mountain part where it was first recognized, and got its name Rocky Mountain spotted fever. It is significant that at least one case of both spotted fever and typhus fever has been reported from every geographic division of this country.

To bring this matter directly into your home state I have tabulated in Table IV similar data for the five states which constitute the West-North-Central part of the United States. Until January 1, 1944, not a single example of Rocky Mountain spotted fever had been observed in the state of Michigan.

TABLE IV. CASES REPORTED IN WEST-NORTH-CENTRAL STATES
1943

	Spotted Fever	Typhus Fever
Ohio	11	0
Indiana	9	1
Illinois	12	1
Michigan	0	0
Wisconsin	1	1

The apparent increase in the examples of spotted fever is well shown in Table V, taken from the studies of Smith and Reinhard.

TABLE V. INCREASE IN SPOTTED FEVER

State	1935	1937	1939	1941
Missouri	0	0	7	13
Arkansas	1	11	23	10
Illinois	2	6	19	17

I might add to this study of Smith and Reinhard, that the first examples of spotted fever were seen in the department of pathology at the Barnes Hospital in the summer of 1941. At that time we reviewed the autopsies for the preceding thirty-one years and re-examined material from all cases in which the diagnosis might have been spotted fever. We did not succeed in finding a single example of the disease. It would therefore appear that, at least in our experience, spotted fever was first seen in St. Louis about 1941.

In order to gain some insight of relative values let us compare the incidence of spotted fever and typhus fever with some conditions ordinarily given far more consideration.

TABLE VI. CASES REPORTED IN UNITED STATES
1941

Disease	Cases	Deaths
Spotted Fever	506	111
Smallpox	1396	12
Tularemia	1531	136
Meningitis	2032	643
Typhus Fever	2787	132
Typhoid Fevers	9086	1061

It is apparent that spotted fever and typhus fever, both as a cause of illness and as a cause of death, deserve more consideration than has been given to them. Typhus fever in the United States causes more illness than does epidemic cerebro-spinal meningitis, tularemia and smallpox. It is almost one-third as common as is typhoid and paratyphoid fevers.

Finally, I must mention that the shipment of American troops to all parts of the world where typhus and tsutsugamushi fever are prevalent completes the picture. American physicians, both in the Armed Forces and in civilian practice, must familiarize themselves with the recognition, prevention, and treatment of rickettsial disease.

Recognition of Rickettsial Disease

It is only proper that, as a pathologist, I confine myself to a consideration of those factors, in the recognition of disease, which come within the province of laboratory medicine. Further, although we must today think of disease in terms of the world rather than of our own country or small community, I shall confine my remarks largely to the distinction between spotted fever

and endemic typhus, since these two occur in the United States.

The first topic then is an exploration of the field of clinico-pathologic correlation. What are the anatomic and physiologic lesions of the rickettsial diseases, and how do these lesions produce the signs and symptoms?

The infectious agent is usually introduced into the body by the bite of an insect—a louse, tick, rat flea or rat mite. Following the inoculation into a susceptible host there is an incubation period, during which time the organisms proliferate and are disseminated to all tissues. As might be expected the incubation period varies with the dosage of organisms and the susceptibility of the host from three to fourteen days. During this time there are few symptoms other than indefinite systemic symptoms of an infection such as malaise, headache, and other ordinary signs. In tsutsugamushi fever and in boutonnose fever a local lesion usually appears at the site of the bite of the insect. There is a punched out focus of bland necrosis, with only slight inflammation of the surrounding tissue.

With the onset of the distinctive disease most of the signs and symptoms are directly related to an inflammation of small blood vessels. The rickettsiae gain entrance to the cells of these vessels and there evoke an inflammatory reaction. In spotted fever there is, in addition, necrosis of the wall, followed in some instances by thrombosis within the lumen. This lesion in the skin inevitably results in the formation of a small focus of inflammation which is slightly elevated, firm and red, either from marked congestion or from actual hemorrhage into the tissue. Hence the name, spotted fever and exanthematous typhus. Occasionally, possibly related to the lesions of the blood vessels, but more likely related to lesions of the nervous system, there are foci of symmetrical gangrene of the trunk or extremities. Not infrequently occlusion of the small terminal vessels to some peripheral part of the body such as the tip of the nose, the lobes of the ears, and the ends of the fingers will result in gangrene. Throughout all of the viscera, but more especially in the serous membranes, there is this same lesion, and hence the appearance of petechiae and ecchymoses in the tissues. In the liver and kidneys there are the usual changes of an infectious disease, that is, cloudy swelling and fatty degeneration of the parenchymal cells. In

the liver this may lead to some enlargement and slight tenderness over the organ because of stretching of the capsule. In the kidney the change in the cells of the tubules and in the cells of the glomeruli lead to a slight albuminuria. In the heart, in addition to the usual vascular lesion, there is not infrequently a mild interstitial myocarditis. This does not become apparent until the second week of the disease when it is reflected clinically by an increase in the pulse rate and by a fall in blood pressure.

In the central nervous system there are distinctive lesions, probably related to the stupor and coma so characteristic of epidemic typhus fever, and seen also in the more severe examples of endemic typhus and of spotted fever. The lesions involve the blood vessels and the surrounding cerebral substances. There are formed in the brain small nodules composed of degenerated nervous tissue infiltrated with gitter cells and other types of inflammatory cells.

In those parts of the world where spotted fever is a relatively common disease, and during periods when louse-borne typhus is epidemic, there is little trouble in recognizing the condition on the basis of clinical sign and symptoms. However, in the United States each physician sees so few examples of either spotted fever or endemic typhus, and many of these are mild, that he is not in a position to make a correct diagnosis in many instances. We must, therefore, turn to the laboratory for assistance in establishing the diagnosis.

Weil-Felix Reaction.—Before discussing the specific immunologic tests for the rickettsioses let me present a general concept of the use of serologic reactions for the diagnosis of disease whether it be typhus, typhoid, or one of many others.

The basic principle to remember is that the animal organism, when it comes in contact with an antigen, will usually elaborate an antibody in proportion to the dosage and duration of contact. There are, of course, exceptions to this statement but we may, for the moment, accept the broad principle.

Now let us assume that a specimen of blood is submitted to a laboratory for some serologic test. The titre is found to be one to one hundred and twenty-eight. The patient has been ill for three days with a disease characterized by the

sign and symptoms of an infection. What are the possibilities? First, the patient may have had this specific disease some years ago and this low titre represents a slight residual immunity. Second, the patient may have had this specific disease many years ago and now has some other related disease which is calling forth a non-specific anamnestic reaction. Third, the patient may have been vaccinated and the titre is related either to residual immunity or to an anamnestic reaction. And fourth, the patient has, for the first time, the specific disease and is beginning to produce antibodies. Decision as to which of the four possibilities is correct is relatively easy, but is too infrequently employed as a diagnostic procedure. A part of the basic concept was that antibodies are elaborated in proportion to the duration of exposure. It is clear then that two determinations of the titre of antibody, one early in the course of the disease and one late, may be of far greater significance. A rising titre, during the course of a disease, is diagnostic. Do not be discouraged and, above all, do not completely reject a diagnosis because the laboratory reports a negative serologic reaction on blood drawn during the first few days of any disease. Parenthetically, I hasten to add that I am not soliciting business for the pathologists of Michigan, although I would not be adverse to this, but only presenting one of the many procedures with which the well-trained professional, clinical pathologist serving as a consultant and not as a technician can make a real contribution to clinical medicine.

The Weil-Felix reaction is one of those bizarre phenomena of biology, which so frequently confuse the investigator. The original observation was that patients with clinical typhus fever develop a rising titre of agglutinating antibody for certain strains of proteus. The probable explanation is that the rickettsiae, and the proteus group of bacteria, contain a closely related or identical antigenic substance (Castenada).

TABLE VII

	<i>Typhus</i>	<i>Spotted Fever</i>	<i>Tsutsugamushi Fever</i>
OX19	+++	+	—
OX2	+	+	—
OXK	—	+	+++

There is a certain degree of cross agglutination with the three strains of proteus, as shown in Table VII prepared by Pinkerton.

Complement Fixation Tests.—Although all of the technical difficulties have not yet been completely overcome, the complement fixation reaction bids fair to be the most specific of the easily determined laboratory procedures.

The antigen is prepared from some source in which the rickettsiae are present in large numbers as, for example, from the yolk sac of the developing chick embryo. Anticomplementary substances are removed and the final test carried out in the usual fashion.

The same principles discussed in the paragraph on the Weil-Felix Reaction apply to an interpretation of the significance of complement fixation tests. A rising titre with a definite reaction by the middle of the second week at a level of 1:128, or 1:256, is secured in endemic typhus. Complement fixing antibodies apparently persist in significant dilutions for at least five years after active infection, and hence are a better criterion of past disease than the Weil-Felix reaction (Bengston & Topping).

Isolation of Organism.—The method of choice for the isolation of rickettsiae, from a patient suspected of having a rickettsiosis, is the intraperitoneal inoculation of five c.c. of blood into a male guinea pig. The blood should be collected during the first week of the disease. A sharp distinction cannot be drawn by this method between typhus and spotted fever, but there are certain differential features of relative value (Pinkerton).

Observation	Typhus	Spotted Fever
Mortality	0	variable
Loss of weight	slight	moderate
Swelling of scrotum	0	usually
Necrosis of scrotum	same basic lesion, but thrombocytosis in spotted fever	
Lesions of vessels	serosal cells,	endothelial cells,
Location of organisms	rarely in endothelium	rarely in serosa

Since the disease in guinea pigs is not always lethal, the temperature should be taken once or twice a day for four to sixteen days to determine if a slight illness has been induced. If a fever develops, the animal may be sacrificed on the fourth to the sixth day and an autopsy performed. The following procedures are desirable:

1. Direct examination of a smear of the scrapings of the tunica vaginalis and the exudate for rickettsiae.

2. Inoculation of blood or scrotal exudate into other male guinea pigs.

3. Preparation of sections for histologic study of at least the tunica, testis, and the brain.

4. Preparation of tissue culture explants of scrotal exudate or spleen.

Further steps in the identification depend on cross neutralization experiments. The most satisfactory technique is to secure known strains of typhus and spotted fever rickettsiae. Guinea pigs are inoculated and the animals which recover are used for the experiment after a period of one month. A guinea pig which has recovered from typhus shows complete immunity on reinoculation with typhus and varied immunity on inoculation with spotted fever. Slight cross immunity is reflected in a prolonged incubation period and decreased mortality in guinea pigs which have recovered from typhus, and are then inoculated with spotted fever rickettsiae. Strains of spotted fever rickettsiae vary greatly in virulence and the protective effect of a previous inoculation in the guinea pig is in general directly correlated with virulence.

Tissue Culture.—It is by this method that a sharp and definite distinction can be drawn between typhus and spotted fever.

The rickettsiae of typhus fever multiply rapidly in the cytoplasm and distend the cell. Nuclei are not invaded but become pyknotic. The organism of spotted fever on the contrary grows most abundantly within the nuclei and only sparsely in the cytoplasm. The explants in tissue culture may be made either of the spleen or of the scrotal exudate.

Incidentally, this behavior in tissue culture is the same as in the arthropod vector with the added difference that typhus rickettsiae are confined to the cells lining the alimentary tract, while those of spotted fever are in all tissues.

Biopsy.—A definitely formed macule should be excised, fixed in Regaud's solution, and stained by Giemsa's method. The lesions are similar in typhus and spotted fever, but necrosis of the vascular walls and thrombi in the lumen are conspicuous features of spotted fever. On the other hand, identification of rickettsiae in the smooth muscle cells of the arteriolar walls is diagnostic of spotted fever, since the organism of typhus is

not found in these cells, but confined to endothelial cells.

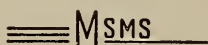
Neutralization Tests.—If the diagnosis has not been established by the end of the second week a neutralization test for the presence of protective antibodies in the serum of the patient may be carried out. The serum is mixed with known infective rickettsiae of typhus or spotted fever and injected intraperitoneally into male guinea pigs.

Summary

Rickettsial diseases are widely distributed in many parts of the world. In the United States there are two important representatives, Rocky Mountain spotted fever and murine typhus. There is not a single geographic division of the United States which, during the year 1943, did not report to the United States Public Health Service at least one case of each of these. There has been an apparent increase of both in the last ten to twenty years; the result either of increased recognition or of actual spread. Physicians in all parts of the country should become familiar with the clinical signs and symptoms of the disease and with those laboratory tests which will assist in establishing the diagnosis.

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Harry E. Plaggemeyer, M.D., presented a case, "Bilateral Pneumopyonephrosis Due to *B. Proteus* *Americanus*," before the Chicago Urological Society at the annual meeting May 24. This is the first case on record in which carbon dioxide pyelograms have been found in a recognized diabetic, caused by the above organism.—*Detroit Medical News*, July 9, 1945.

Bronchial Asthma

Diagnosis and Treatment

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Effective treatment of Bronchial Asthma depends upon avoidance of the allergenic factors, and desensitization when indicated. There is no short-cut to finding the offenders. Every available recognized procedure should be incorporated in determining these factors. An adequate history is one of the most important items in revealing the major allergens. This in conjunction with other procedures helps solve most of the diagnostic problems encountered in Bronchial Asthma. This paper deals with a working routine in arriving at an etiologic diagnosis of bronchial asthma, giving valuable aids in extracting important information and clues.

■ In approaching any allergic problem a definite program must be followed, aiming primarily at an etiological diagnosis. When the underlying causes have been ascertained, specific measures of treatment can then be instituted. Attempting to treat asthma and related conditions solely with symptomatic medication deprives the patient of the opportunity of becoming a comfortable citizen, and threatens him with the constant danger of exacerbations. It is not only important to determine the nature of the asthma but also that of related allergies. Knowledge of existing complications is important for proper management of the entire condition. When one is positive that he is dealing with an allergic manifestation, his efforts are then directed at unfolding the specific underlying factors, which are chiefly in the nature of inhalants, foods, drugs or bacteria.

There are several steps to be taken in reaching conclusive clinical evidence. Of utmost and primary importance is a detailed history. Next, a thorough physical examination should be undertaken with special attention to organs involved,

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accompanied by skin tests, and routine and special laboratory procedures. Finally, measures aimed at proper dietary management are used as a therapeutic test; then specific treatment may be instituted. Throughout the study, the patient should be kept comfortable with palliative measures. The ultimate goal is the discovery of the offending allergens, so they can be eliminated, where possible, and specific desensitization applied where indicated.

History

In approaching the problem at hand the most important single diagnostic procedure is a detailed history. Many clues can be obtained which otherwise would remain unrecognized if the patient is guided through a chronological résumé of all illnesses, with special stress on allergic manifestations. The patient frequently does not realize the scope of symptomatology which may be attributed, in whole or in part, to reactions of hypersensitivity. It is, therefore, of extreme importance to approach each common allergic manifestation by asking leading questions.

In infancy and childhood, eczema and feeding problems are usually the earliest manifestations of an allergic nature. Thorough and carefully taken histories will often elicit these important facts. Other complaints which should be made a matter of record are urticaria, angioneurotic edema, conjunctivitis, frequent respiratory involvements, canker sores, headaches, gastro-intestinal upsets, chronic fatigue, hayfever, perennial rhinitis and sinusitis. These may all be allergic in origin, and when elicited in the present or past history, may finally prove to be on the basis of the same or related underlying allergic background.

In bringing out all historical details of past allergic manifestations, one is better equipped to proceed with the problem at hand, namely, bronchial asthma. If, at this point in the history, suggestive evidence has been revealed, these factors can be utilized in treating the existing asthma. Their significance will become apparent during the course of the illness. If, for example, milk was a known clinical offender in previous years, having caused some allergic condition other than the asthma, it might at present also be one of the factors of significance. It should, therefore, be eliminated from the diet temporarily, and returned with the object of causing a slight upset

after the patient has been completely relieved of all symptoms.

One should next proceed with a chronologic recording of the asthmatic attacks in relation to age of onset, time of year when exacerbations are most prevalent, duration of symptoms and known factors which precipitate the attacks. In cases where difficulty or exacerbations occur only during a specific time of the year, a helpful clue is thus obtained. For example, the predominant inhalant factor during the early spring and early fall months is dust. Closing the doors and windows and turning on the heat in the fall causes an increased concentration of dust in the home. In the early spring, the trees pollenate and may add or precipitate attacks of asthma as well as hay fever. Grass pollen appears in the early summer months, but is pretty well out of the air by mid-July. If the major complaint occurs from approximately the middle of July to August, before the ragweed family pollinates, fungus sensitivity is strongly suggested. This factor may also be a perennial cause of asthma but the peak of its presence in the air is reached during the midsummer period. Any combination of inhalant factors may cause asthma and thus make the picture more complicated. Allergy due exclusively to foods usually improves during warm weather, unless the food is a seasonal one precipitating symptoms only when ingested. On the other hand, improvement during the summer months may mean that the patient is not being exposed to as great a concentration of inhalant factors in the home because of increased outdoor activity.

During an attack of bronchial asthma, the symptoms may fluctuate during a twenty-four-hour period. It is important to note the time of day when symptoms are definitely aggravated or are more apt to appear. If this occurs following meals, it is suggestive of either a food or physical allergy. Hot or cold foods may be the causative or precipitating mechanism. Symptoms which occur only after retiring are strongly suggestive of offending allergens being present in the patient's room. Inhalants such as dust, feathers, orris root and cosmetics are present in this room in greater concentration than elsewhere. They may be harmful only in such large exposures as contacted during the sleeping hours, and thus cause asthma at night or in the early morning hours. On the other hand, it may be due to the pathological physiology incident to this con-

dition. Foods can, and often do, cause symptoms during the night as well as during any time of the day. The delayed reactions, in relation to food offenders, are more common than immediate ones and therefore much more difficult to ascertain.

Atmospheric alterations, such as temperature and humidity changes, are often responsible for precipitating attacks. Rapid changes of weather will often result in an acute episode. As a working explanation, it is not untenable that with atmospheric alterations a general increase in tissue fluids occurs and the patient who is on the verge of an attack may be thrown into the symptom class. Other factors such as menstruation, pregnancy and bacterial disease may serve also in lowering the patient's allergic threshold. Under average conditions, the patient may get along in apparently perfect health with no obvious difficulty in breathing. When the above-mentioned additional factors enter the picture, the patient's tolerance is lowered and symptoms precipitated. In such individuals, the allergenic substances are not present in sufficient quantities, under average conditions, to cause a disturbance in the shock organs, but they are constantly close to the border or on the verge of an upset. As long as the bronchial tissue is not aggravated, the patient remains within the zone of health. The allergic tolerance varies from day to day and may explain at least in part the fluctuations in asthmatic symptoms. This also helps explain the reason an allergic individual who is a potential asthmatic may not experience symptoms for many years. This eventually occurs when the allergic threshold is exceeded. It may also explain the reason patients can at times be well controlled by proper allergic management of one phase of sensitivity (food or inhalants), when, actually, multiple factors are at fault. This fact often gives the doctor the erroneous impression that only one factor is of significance. It is therefore well to keep this explanation in mind as a working basis in treatment as well as in diagnosis. If, at one time, the patient responds solely to dietary management, and at other times does not, it means that the therapeutic approach is not entirely correct and that additional offenders may be responsible.

Detailed questions are directed toward determining the effects of environment in relation to bronchial asthma. The length of time a patient has resided in his present location, where he lived previously, the difference of health in the various

localities, and the presence of surrounding fields with unruly vegetation are all points of extreme significance in seasonal and perennial cases. Sometimes an important clue is revealed when the patient states that he notices slight dyspnea when in the cellar or attic of his home, thus suggesting dust or mold sensitivity. When symptoms occur in relation to contact or close proximity to a new object of furniture, for example, when the sufferer is definitely worse when sitting in an easy chair, animal dander and other materials used in stuffing these items is suggested. The type of heating device may be of importance. Other questions should be directed towards eliciting an intolerance to dust. This can easily be done by making inquiries regarding the effects of exposure to dust, either at home or at work. Pets, plants, cosmetics, furs, insect sprays and numerous other items with which the patient daily comes in contact at work or at home may be the sole or major cause of the difficulty. Sometimes inquiring into a patient's hobby reveals a significant factor. The materials used and the environment in which any special hobby is engaged in should be recorded and evaluated.

Drug sensitivity is a common source of trouble in allergic individuals, and should not be overlooked as a possible offender. It is not sufficient merely to ask whether a patient uses drugs or other medications. They frequently do not consider such items as aspirin, laxative, or other habitual proprietaries in this category, and therefore give answers in the negative. Specific questions naming all possible lay medications should be directed to facilitate the patient's memory. The effect of foreign protein in past treatment is of importance. Serum sickness, which frequently follows injections containing horse serum, has been experienced by many individuals in past years and should be made a matter of record.

Often the greatest aid in reaching the etiologic objective is obtained from the least suspected source. Therefore, what appears as a short cut in history-taking ends up in a detour or blind alley. Psychogenic factors should be sought for routinely. Emotional upsets, nervous tension and extreme fatigue may all act as a "trigger mechanism" in precipitating attacks of asthma. To consider these psychogenic factors as primary and exclusive causes, I believe is placing the cart before the horse. It is possible, however, that in an allergic individual, once the train of asthmatic

symptoms has been set in motion, other influences which upset the autonomic or vasomotor system's balance may also precipitate attacks.

The patient is, at this point in the history, allowed to give some of his own impressions as to what he believes are the extenuating circumstances which aggravate or precipitate the asthma. Important clues are frequently obtained in this manner, and the patient is given an opportunity to express his opinion. Food, as a cause of asthma and other allergies, is extremely important and should be dealt with in sufficient detail, which cannot be given to this subject in a paper of this type. All food dislikes should be recorded, because they often parallel actual clinical offenders. The patient is not always able to state specifically that he does not like a food because of its apparent harm, but such a statement should be sufficient evidence that elimination of that item during a trial period is indicated. Specific questions regarding each common food substance ingested daily will bring out more evidence than a single question directed at determining foods regularly causing allergic symptoms when eaten. For example, he is asked the number of slices of bread eaten per day, the number of eggs per day or week, the amount of milk, juices, etc. Some of the symptoms produced by the common daily foods are not necessarily directly related to asthma but may cause minor allergic upsets in other shock organs. Although immediate effects may be noticed in parts of the anatomy far removed from the lungs, the same foods may be causing delayed effects on the bronchial tissue. Other factors in the usual medical history must also be completely elicited so that a balanced picture of the patient's entire illness is obtained.

Laboratory Tests

The usual routine laboratory procedures such as blood counts, urinalysis and blood serology are performed as in other medical conditions when indicated. The sputum and nasal secretion should be examined, mainly for the presence of eosinophils. X-ray examination of the chest is an important and worth-while diagnostic procedure revealing complications which might otherwise cause greater difficulty in the management of this condition.

Specific Tests

In the past few years, skin tests have been popularized as a diagnostic aid in allergic con-

ditions. It is important to bear in mind that such tests are not infallible and should be classed with other helpful laboratory procedures. If one realizes the limitations of such tests, he is more apt to obtain the maximum knowledge they afford, at the same time not overemphasizing their importance. The two types of tests in common use are the scratch and intradermal techniques. In both procedures, extracts are prepared from allergenic substances. In the scratch tests, superficial scratches approximately 5 mm. in length are made on the skin of the arm, forearm or back. Concentrated extracts are applied and allowed to act on these areas for 15 to 30 minutes. Positive reactions appear in hypersensitive individuals in the form of wheals and erythema surrounding the original scratches. The intradermal tests are performed over similar sites by injecting small quantities (0.03 c.c.) of extract which has been properly diluted. In comparison, the reactions obtained are ten times stronger than those obtained from materials in the scratch method. It is always well to begin testing with the scratch technique since these are less apt to cause constitutional reactions. There are cases on record where severe shock and even death resulted from scratch and intradermal tests. The scratch method is less sensitive, and therefore positive reactions are of greater significance when they do occur. On the other hand, it is difficult to ascertain borderline reactions. Therefore, after having made initial observations with this type of testing, intradermals with selected items are next indicated. In performing these, the same syringe and needle should not be used for more than a single item. If multiple tests are performed with the same equipment, false reactions may occur from even the minutest quantity of extract remaining from previous injections. For the sake of accuracy in obtaining what information it can possibly reveal, a complete set of syringes and needles must be maintained so that the same sets will always be used for the same materials. In spite of the utmost precautions, false reactions are common, especially in those patients who give strong true positive reactions to ragweed. On the other hand, negative reactions do not rule out the possibility of clinical sensitivity still existing. In performing skin tests, we are only determining the reactivity of one organ, namely, the skin, which does not always reveal the state of sensitivity existing in the bronchial tissue. With the

appearance of positive reactions, it must be kept in mind that present clinical sensitivity to an allergen must be finally judged by its ability to precipitate clinical reactions.

After recording the reactions of all the tests in the form of 1 plus, 2 plus, 3 plus or 4 plus, a decision must be made as to which are of present clinical significance. If, for example, wheat gives a positive reaction, but feeding of large quantities of this substance does not increase or precipitate the asthmatic state, wheat is then not considered a present clinical offender. This substance might have been the cause of other allergic manifestations in the past, and the skin still reveals a positive reaction in the form of a memory response. The size of the reaction does not necessarily reflect the degree of clinical sensitivity. A doubtful or plus-minus reaction may be of greater significance than a 2 plus, therefore, elimination on the basis of the severity of the reaction should not be the method of approach. If the skin tests are not given undue importance, applying them in the same manner we would consider other laboratory procedures in medicine, and correlating these findings with impressions obtained from other diagnostic measures, they render their greatest assistance.

Passive transfer tests which are performed by intradermal injections of small quantities of the patient's serum into a nonallergic subject causes sensitization of these areas in from 24 to 48 hours. These sites can then be used for direct testing with specified allergenic substances by the scratch or intradermal technique. This transfer of reacting bodies or antibodies from one individual to another affords a means of skin testing in infants without exposing the child to their possible dangers. The leukopenic index is often a helpful laboratory procedure in determining the allergenic status of food. When other methods do not reveal conclusive evidence about foods, it is well to keep this additional laboratory procedure in mind.

Diets

Hyposensitization with suspected inhalant allergens can be started as soon as these factors are ascertained. Dietary management should accompany such treatment. Having received all the available information from the history and special tests, we are now ready to proceed with dietary management. First an attempt is made with a

diet eliminating all suspected foods. If, after a period of ten days or two weeks, no benefit has been derived, the patient is then placed on Rowe diets or one of their modifications. The patient should never be kept on a given strict elimination diet for too long a period. If, within a week or two, no apparent change occurs, one must conclude that the patient was either not clinically sensitive to any foods, or that the offending items still exist in the present diet, in whole or in part. The latter instance is often the correct interpretation of such poor results. On the other hand, when good results are obtained shortly after inauguration of a basic diet, new foods should be added one at a time, in large quantities, at approximately three-day intervals in an attempt to upset the patient. If asthma recurs in relation to the newly added food, that substance is then considered a definite clinical offender, and must again be omitted. There are many pitfalls in food management, and more detailed information may be obtained from recent texts on the subject. Suffice it to say that foods, as other allergenic substances, may be the cause of delayed reactions or upsets based upon the cumulative doses of the offenders so that no strict and fast rule can be applied to the specified time that may elapse before a reaction occurs.

As an aid in keeping a patient on a strict diet, and also giving the doctor a means of checking on it, a food diary is extremely important. This consists of a chart on which the patient records each item of food and also notes the daily reactions. Frequently this reveals possible offenders; but if it does nothing more it indicates to the patient the extreme importance of close adherence to the specified diet. With adequate dietary control, elimination or avoidance of inhalants or contact offenders, and proper hyposensitization, the majority of patients can be kept free from the distressing symptoms of bronchial asthma.

Symptomatic Treatment

It is well to have at hand certain emergency measures to combat any unforeseen upsets. Such drugs as are used for palliative administration are sometimes indicated. The drug of choice in bronchial asthma is epinephrine. The aqueous preparation in a 1:1000 dilution is used in doses of 0.3 to 1.0 c.c., injected subcutaneously as required. Epinephrine in oil given intramuscularly may be

used in 1.0 c.c. doses when a prolonged effect is desired. Epinephrine inhalations are of definite benefit, and can be administered by the patient as necessary. A 1:100 solution of epinephrine chloride is instilled in a special inhalation apparatus and prompt relief from asthmatic symptoms may be obtained shortly after its inhalation. Ephedrine by mouth in the form of the sulfate or hydrochloride in doses of $\frac{3}{8}$ or $\frac{3}{4}$ grain may be very helpful in relieving minor attacks. Sometimes the combination of ephedrine and aminophylline with some sedative may enhance the desired action. Synthetic ephedrine or ephedrine-like products are on the market, and may sometimes be preferred because of the absence of toxic reactions. Aminophylline administered intravenously in doses of $3\frac{3}{4}$ to $7\frac{1}{2}$ grains is an excellent drug for obtaining relief from attacks of bronchial asthma, and often is more effective than epinephrine. This is especially useful when a patient becomes "epinephrine-fast." Rectal suppositories containing $3\frac{3}{4}$ grains aminophylline, instilled as often as every six hours, may keep the patient symptom-free or reasonably comfortable during times when asthma is inevitable. The iodides are still very useful in many cases and are usually administered orally in the form of potassium iodide, 15-20 minims three times a day. In more severe attacks, a mixture of equal parts of ether and olive oil may be instilled per rectum with considerable benefit. This is made by whipping together three ounces of ether and three ounces of olive oil, then slowly instilling it per rectum by means of a small-caliber catheter. During major upsets, oxygen or oxygen mixtures with 80 per cent helium and 20 per cent oxygen may be given by tent or through a B.L.B. mask. Hypertonic solutions of glucose, either 50-100 c.c. of 50 per cent glucose or 500-1000 c.c. of 10 per cent glucose in saline, given intravenously either alone or with aminophylline proves to be very effective. Other measures such as saline lavage of the bronchial tree through the bronchoscope, or repeated whole blood transfusions are often very helpful. There are many other forms of non-specific and palliative treatment but it is not the scope of this paper to deal with all of them. If the routine, as outlined in this paper, is followed, the majority of cases of bronchial asthma will be benefited.

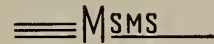
Conclusion

A complete history can give more information

regarding the etiologic factors in asthma and other allergic diseases than any other single diagnostic measure. It should be utilized to the fullest extent and much time should be given to obtain the necessary data. In conjunction with other measures which have been outlined in this paper, the underlying clinical offenders can be discovered, and by their elimination the patient can be returned to a better state of health.

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ARMY FIGURES DEPICT MEDICAL PROGRESS

Comparative figures of World War I and World War II are most illuminating and offer convincing proof of advance in the science of medicine and in the efficient organization of the medical department of the Army.

Brigadier General Hugh Morgan is authority for the following comparative figures:

	World War I	World War II
Death rate in wounded.....	8.1%	3.3%
Meningitis mortality	38.0%	4.0%
Pneumonia mortality	28.0%	0.7%
Dysentery mortality	1.6%	0.05%
Annual death rate per 1,000 for all diseases in the Army, excluding surgical conditions	15.6%	

We have an overwhelming pride in the innumerable acts of heroism of the doctors, nurses, and corpsmen, and in their exhausting efforts on behalf of the sick or wounded soldier. We have great pride in the medical department organization which has projected medical care to the front line and has worked out a system of evacuation of the wounded which has saved thousands of lives. We have a justifiable pride in American Medicine which has provided the Army with doctors of high caliber and proper training, who possess a scientific knowledge that has made the above favorable comparison possible.

The Need for Cancer Education in Secondary Schools

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M.D., George Washington University Medical School, Washington, D.C., 1907; engaged in public health work for many years; made the first complete study of health and medical work in prisons and reformatories in the United States, 1928; Executive Secretary, Chicago Medical Society, 1929; Field Representative American Cancer Society, 1930-1941; Cancer Consultant, Michigan State Medical Society and Michigan Department of Health; Fellow A.M.A., Institute of Medicine, Chicago, A.P.H.A.; Member Executive Committee, Public Health Cancer Association; Honorary Member, A.A. of I.P. and S.

Cancer is a serious disease in childhood. During the past five years it has caused an average of 115 deaths in Michigan under the age of twenty.

Childhood cancer differs from cancer in adults in distribution and symptoms. Pain, fever, anemia and weakness often accompany its onset, and as these symptoms also indicate acute infections, their relation to cancer is often overlooked until too late.

Education of physicians, nurses, teachers and parents is necessary to a better control of cancer in younger ages.

■ CONTRARY to popular opinion, cancer is a serious and not uncommon disease of childhood and adolescence. In 1941 almost two per cent of all cancer deaths in the United States occurred in persons under twenty years of age. In these deaths are included the deaths from leukemia, which is universally recognized as cancer of the blood cell forming tissues, the bone marrow and spleen, although given a separate listing in the International List of Causes of Death.

Many cases of cancer in childhood are overlooked until late stages, for many of the early symptoms resemble those of acute infections. Fever, anemia, weakness and pain are all common symptoms of infections; they also accompany many types of cancer in younger age groups. Because of this confusion in diagnosis, treatment often is deferred until the patient has become hopelessly incurable and only palliative therapy can be employed.

The common types and sites of cancer in childhood also differ from those found most frequently in adults. In general the kidneys, central nervous system, eyes, bones, spleen and bone mar-

row, are most often involved in cancer in these younger age groups. These same tissues are much less commonly involved in adults.

Cancer in childhood usually runs a rapid course, metastasizing early and widely. Few cases run a prolonged and chronic course. The duration of the illness may be measured in weeks or months in children, compared to years in adults. In general, the prognosis is most unfavorable in children because of the rapid growth and spread of the disease and the delay in seeking medical examination and treatment.

The distribution of cancer in childhood follows rather definite age patterns. During the first five years, embryoma of the kidney, or Wilm's tumor, neuroblastoma, central nervous system tumors, eye tumors and leukemia predominate. During the second five years, few Wilm's tumors are seen, and eye tumors are less common, but brain tumors and leukemia continue to be found quite frequently. During the second decade, bone tumors are found very often, the others mentioned less often, and some of the cancerous growths found most often in adults are beginning to make their appearance.

By this brief analysis of differences in its nature, occurrence and distribution in children as compared to adults, it is seen that cancer in younger age groups is a serious problem demanding serious consideration by parents, school teachers and public health officials, as well as by the medical profession.

The following descriptions of cancerous growths in childhood are not intended to be exhaustive, but rather to emphasize some of the major characteristics, especially those signs and symptoms that would be most evident to public health and school officials who are called upon to evaluate the child's health status. Those who wish a more detailed description of each type of malignant growth are referred to textbooks and other medical literature.

Embryoma of Kidney or Wilm's Tumor

This tumor is seen most often before the fifth year of life. It affects both sexes in equal proportions and is usually confined to one kidney. It is painless in most cases, and usually diagnosed by a swelling over the involved kidney that increases the waistline measurements. On palpation a smooth or slightly nodular tumor is felt that seldom crosses the midline. There is rarely blood in the urine, but there may be a moderate fever of

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101 to 104 degrees. This tumor does not spread to the liver and bones. The lymph nodes and lung are favorite metastatic sites.

The treatment of choice is surgical removal with postoperative irradiation. The prognosis is unfavorable; at least 75 per cent result fatally.

The main diagnostic point to be emphasized in this type of cancer is that of painless, unilateral swelling over the area of the involved kidney.

Neuroblastoma

Next to Wilm's tumor, neuroblastoma is the most frequent type of abdominal tumor found in infants and young children. It often arises from the adrenal medulla, grows rapidly and spreads widely, especially to the liver, lymph nodes, bony orbit and skull; less frequently to the lungs.

The principal symptom is painless abdominal enlargement accompanied by pallor, weight loss and some fever. The tumor mass is usually nodular and crosses the midline. Due to its rapid growth it may soon cause dyspnea, hypertension, constipation and other pressure symptoms.

Treatment is surgical removal with postoperative irradiation. The prognosis is always grave. There are few recorded cures.

As with Wilm's tumor the principal sign is a painless abdominal enlargement, and those caring for or examining children of preschool age should always keep these two types of cancer in mind.

Brain Tumors

Brain tumors, not all of which are of a cancerous nature, occur quite frequently in childhood and adolescence. Many of these have a favorable outlook, provided they are recognized in early stages and are treated by competent neurosurgeons.

Many of these tumors are found in the cerebellum, where they produce both motor and sensory symptoms. While the train of symptoms will depend largely on the brain areas involved, vomiting, headache, and visual disturbances are cardinal symptoms of intracranial pressure. In the very young, hydrocephalus may be seen with separation of cranial sutures. Vomiting is explosive and recurrent and unrelated to taking of food. Muscular inco-ordination is frequently seen with disturbances of sensation. When the sixth cranial nerve or optic tract is involved, visual disturbances will develop. Personality changes are common, especially in older children. A formerly

attentive, studious and well-mannered child may develop the opposite characteristics.

A child showing any of the above or related signs and symptoms, should be examined by a competent neurologist rather than be subjected to disciplinary treatment on the basis of his insubordination.

At least 50 per cent of brain tumors are favorable for surgical removal, provided they are diagnosed in relatively early stages before permanent damage to the brain tissue has resulted from pressure of the growth. The remaining 50 per cent, classified as unfavorable, are not suitable for surgical removal, either because they have spread to vital brain areas or to other tissues, or because their location renders removal extremely hazardous, often with a mortality of 30 to 40 per cent. In many of these cases that are subjected to operation there is a fatal recurrence due to inability to effect a complete removal of the tumor at time of operation.

Retinoblastoma or Glioma of the Eye

This tumor is seen most often in infancy and early childhood. The majority of patients with this type of tumor will give a history of similar condition in one or more generations of ancestors. In about 20 per cent of cases, both eyes will be involved, the condition originating in one eye and later involving the other. It is often present at birth, and is one of a very few types of cancer that has a proven hereditary factor.

Dilatation of one pupil and a grayish-white cloudiness of the eyeball—the so-called "cat's eye" appearance—are the two cardinal symptoms of this tumor. There may be enlargement and protrusion of the eyeball. Pain is frequently present, and in children old enough to notice there will be visual disturbances.

Treatment comprises enucleation followed by irradiation. With bilateral involvement, the more seriously affected eye may be removed and the other one subjected to irradiation in the hope of saving the second eye, or at least of prolonging its usefulness.

The prognosis is always grave, and with involvement of both eyes there is great danger of complete destruction of vision even though the patient's life may be saved.

Cancer of Bone

Bone cancers in children occur most often in the second decade of life, and are found more

often in males. Their favorite site is at or near joints of long bones, the knee being a favorite joint for their development.

Pain, swelling, and tenderness at or near the involved joint are cardinal symptoms of bone cancer. Fever, loss of appetite, and "night cries," due to the fact that these cancerous growths are more painful at night, are also common symptoms. It is felt that injury has a more direct relation to this type of cancer than to any other. Many of these patients give a history of rather recent and severe injury to the involved area.

These cancers are often initially diagnosed as rheumatism or "growing pains," and treatment delayed until the condition has become hopeless. Every patient with a history of injury and exhibiting the above-mentioned symptoms should have an x-ray examination of the bone complained of. In far too many cases the x-ray examination is postponed while other and ineffectual methods of treatment are being tried, thus condemning the patient to an early and untimely death.

Treatment consists of excision of the tumor area in the case of benign growths; of amputation well above the tumor site for all cancerous growths. It is unsafe to rely on irradiation alone for any of the malignant bone tumors. Ewing's tumor usually will respond well in the beginning to irradiation, and this has led some physicians to the erroneous conclusion that it could be eradicated by such treatment, only to find it had recurred at a later date with a fatal result.

Leukemia

The acute lymphoid and acute myeloid types of leukemia are found most often in younger age groups.

The *acute lymphoid* type is seen especially in children under the age of ten, and because of similarity of symptoms, it is often confused with acute infections. Arthritic pains with swelling of joints, fever, weakness and anemia, suggest acute articular rheumatism. These joint pains are particularly severe in some cases. Slight bruising and injuries will cause wide-spread bleeding into the tissues. Because of this, anemia is often severe. There may be a mild leukocytosis, but leukopenia is frequently encountered. The spleen and lymph nodes may be moderately enlarged.

An acute infection, such as laryngitis or head cold may initiate the onset.

Treatment is palliative only, as the disease is

considered incurable. Irradiation will at times hold the disease in check for varying periods of time. The prognosis is hopeless, death usually occurring in a few weeks or months.

The *acute myeloid type* of leukemia occurs more often after the tenth year of life. The principal symptoms are anemia, fever, and weakness. The onset often simulates a severe infection especially of the upper respiratory tract. There is no leukocytosis in the majority of cases. The spleen may be but moderately enlarged.

Treatment is palliative only, as the disease is incurable. Irradiation is helpful in prolonging life. Prognosis is hopeless.

The diagnosis of these leukemic conditions is made on examination of the blood, the predominating abnormal type of white blood cell indicating the form of the disease present in a given case.

Other Types of Cancer in Childhood

While the types of cancer that have been discussed are found most often in children, cancer in many of their other organs and tissues has been found at times. Cancer of the breast, uterus, gastrointestinal tract, lungs, endocrine glands and skin are among the other types most frequently encountered. Xeroderma pigmentosum, an intensive concentration of pigment in the skin made worse by exposure to sunlight, and neurofibromatosis (von Recklinghausen's disease), are two types of cancer found in childhood and adolescence.

Suggestive skin signs of cancer in children with which all physicians, nurses and school officials should be familiar are the following:

Moles and warts that show changes in size, shape or color due to irritation or prolonged exposure to sunlight. Intense freckling due to short exposures to sunlight—Xeroderma pigmentosum. Swellings in lymph node areas, as groin, axilla, or neck. Pale mucous membranes and sclera, indicating anemia.

Comparative Mortality

Having reviewed the types of cancer found most often in childhood and adolescence, a word about the extent of cancer in these age groups may be in order. Is the disease encountered sufficiently often to warrant special measures for its control? The national vital statistics reports will give some interesting comparisons with other diseases considered of major importance in this

DEATHS FROM CANCER AND CERTAIN OTHER
DISEASESUnder Twenty Years of Age
Michigan—1939-1943

Year	Cancer (including leukemia)	Acute rheumatic fever	Diphtheria	Measles	Poliomyelitis	Scarlet fever	Syphilis	Tuberculosis	Typhoid fever	Whooping cough
1939	103	95	19	28	32	54	25	230	9	76
1940	107	56	10	18	54	32	22	214	4	57
1941	131	54	17	65	17	27	24	182	5	90
1942	107	39	21	8	10	17	11	195	1	70
1943	130	58	15	85	21	9	15	180	3	101
Total	578	302	82	204	134	139	97	1001	22	384

younger age group. In the United States in 1941, under age of twenty, there were 1,687 deaths from cancer, and 1,147 deaths from leukemia, or a combined total of 2,834 deaths from these cancerous diseases. As mentioned previously, this is almost two per cent of all cancer deaths that year. During this year, tuberculosis, a notorious killer in early life, claimed 6,069 lives, and whooping cough, also a dangerous disease among young people, caused 3,769 deaths. The following diseases, always considered of great importance in younger ages, gave the following number of deaths: measles, 2,001 deaths; syphilis, 1,405 deaths; diphtheria, 1,182 deaths; acute rheumatic fever, 765 deaths; poliomyelitis, 607 deaths; scarlet fever, 378 deaths; and typhoid fever, 351 deaths. Thus we find cancer ranking third as a cause of death among the diseases most commonly affecting these younger ages.

In Michigan, the place of cancer as a killer of young people is more prominent than in the country as a whole, tuberculosis alone outranking it in the list of diseases mentioned previously. For the five-year period, 1939-1943, cancer consistently outranked each of the other causes of death mentioned by from 154 to 556 deaths.

It may be argued that if it were not for immunization, vaccination and quarantine, deaths from several of these communicable diseases would be much greater. The proposition might also be advanced that if a small fraction of the time, effort, and money now spent by private and official health agencies on many of the other diseases mentioned was spent on the study of cancer in these younger ages, and on educating pu-

pils, teachers, parents, health officials and physicians in the control of the disease by recognition of early signs and symptoms and the absolute necessity for prompt and adequate treatment, a different cancer mortality situation would soon prevail among children and adolescents.

A person is as dead from cancer as from any other cause, and society suffers as great a loss by such deaths as it does by deaths from tuberculosis, poliomyelitis, or syphilis, for example. I would not suggest for one moment any decrease in any part of the program for control of any of the common communicable diseases; but would urge that increased emphasis be placed on the control of cancer in these younger age groups.

Control Measures

As many of the cancerous growths discussed in this paper occur in early life and before the habits of the patient have been able to influence their development, they offer much less chance of prevention than do many types of cancer in adults. Control rests largely on their recognition and proper treatment in early stages. Their recognition in early stages will be facilitated by an appreciation of the fact that cancer can and does occur in younger age groups; that a knowledge of major signs and symptoms of the types of cancer encountered in these ages is essential to early recognition; that prompt diagnosis of suspicious conditions with prompt and proper treatment as soon as cancer is found will go far toward saving the patient's life.

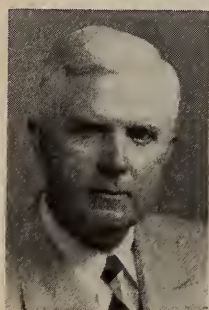
Health officials, especially those coming in close and frequent contact with children and adolescents, the medical profession, school authorities, and parents all should keep these facts in mind. Unless this is done, cancer is almost sure to take an increasing toll of lives of these future citizens.

The subject of cancer education in secondary schools was discussed at this same meeting a year ago, and the very sound and reasonable arguments in its favor advanced at that time need not be repeated or reviewed here. To anyone who has given any thought to the subject, the value of such an educational program as a general health-promoting and life-saving undertaking is unmistakably clear. Your essayist can only hope that the points emphasized in this paper will focus attention of education and health workers more directly on this problem.

Penicillin in Ophthalmology

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Penicillin is very efficient in treating conjunctivitis, especially gonorrheal conjunctivitis and orbital cellulitis as well as any other form of infection around the mouth and neck. It is a marvelous drug in the treatment of meningitis. In deep infection of the eyes such as iritis, uveitis and retinoboroiditis it is of no value since there is very little penetration of the eyeball by penicillin. This drug may be used with sulfadiazine, frequently with improved results. Intramuscular injection is the most satisfactory for all purposes. In meningitis, additional injections intrathecally should be used. Locally, it may be used in strength of 500 to 800 units per c.c. or better, in the form of ointment made fresh for each case and kept in a refrigerator.

■ THE practice of medicine has made more progress in therapeutics in the last 35 years than in any century in the world's history. Prior to our time quinine in malaria was revolutionary. Then came Ehrlich with salvarsan, Bunting with insulin and then the sulfa drugs.

In 1877 Pasteur observed that the infective power of the anthrax bacillus was greatly reduced when it was contaminated by certain saprophytic bacteria. This showed an antagonism between different microbes.

In 1929 Fleming observed that a strain of a fungus *penicillium notatum* growing on agar plates inhibited the growth of pyogenic cocci. The active principle of this antagonism was found to be what is now called penicillin. It is particularly effective against Gram-positive organisms. Broth containing penicillin was injected into mice and was no more toxic than plain broth. Nothing much more was done with the product until Chain and his associates published their work in the *Lancet* in 1940. At first only small quantities could be produced. Its results in clinical practice were so striking that it became apparent that mass production was very necessary. It takes about 100 liters of the medium to produce 1 gm. of therapeutic penicillin. The greatest precautions must be taken against contamination, as certain

bacteria can greatly reduce the production of penicillin. It is easily destroyed by acid reactions, but is fairly stable in the sodium or barium salt.

You have probably all seen pictures of the large scale production facilities in some of our drug manufacturing plants. The purified penicillin is capable of inhibiting the growth of staphylococcus aureus at a dilution 1:24,000,000 and 1:30,000,000. The standard of activity is the Oxford unit which is the amount of penicillin per milligram just capable of inhibiting a growth of staphylococcus aureus dilution of 1:50,000.

The beauty of the drug is that it seems to have no serious toxic effects, Hobby and her associates were unable to detect any destruction or absorption of penicillin by the organism. Penicillin is not inhibited by serum, tissue extracts or products of tissue breakdown.

The lethal toxicity of penicillin is much less with the more refined preparations. In mice, a single intravenous dose of 30,000 units or daily subcutaneous doses of 192,000 units per kilogram precipitated severe toxic reactions, such as restlessness, a fall in temperature, watering of the eyes and dilatation of the venules of the ears and at the corneoscleral junctions. Four out of ten of the animals died. In humans a single dose of 200,000 units was given with no toxic symptoms.

The penicillin is grown in a modified brown sugar medium. The penicillin formation begins about the fifth day and reaches its peak on the eleventh to the thirteenth day. The presence of zinc was demonstrated to be of major importance both in the growth of the mould and the production of penicillin. Foster believes that the zinc acts as a catalyst to the oxidation and utilization of glucose by the mould, thus preventing the formation of gluconic acid which causes a drop in the pH of the medium.

Penicillin was readily absorbed in animals after intramuscular or subcutaneous injection, and from the small intestine. It could not be given by mouth because the acid of gastric juice destroyed it, or by rectum, as the bacteria present there inactivated it. It was largely excreted, still in an active form, in the urine of the mouse, rabbit and cat, and to a certain extent in the bile and saliva; *not* excreted in tears or pancreatic juice of cat.

His observations agreed with Fleming's in that it was found that the action of penicillin was bacteriostatic, in that it merely inhibited the

growth of organisms and did not kill them quickly.

It was found that pus, tissue autolysates, blood and serum had no inhibitory effect on the activity of penicillin.

Their "mouse protection tests" established the fact that with appropriate dosage almost complete protection was afforded to batches of mice infected intraperitoneally with lethal doses of streptococci and staphylococci and intramuscularly with *Clostridium septicum*.

Their first injections in the human subject disclosed that there was some substance present in the crude penicillin preparations that caused a rigor and sharp rise in temperature. The pyrogenic effect was due not to the penicillin but to an impurity which could be and was removed.

Rammel Kamp and Kufer found that when the drug is given intravenously in 40,000 units, the peak of inhibitor level of 2.5 units per cubic centimeter of serum took 185 minutes to fall to a subinhibitory level; whereas with 5,000 units, the peak concentration was only 0.156 units per c.c. and fell to a subinhibitory level in thirty to forty minutes.

The amount of penicillin that penetrates the blood cells is exceedingly small and is usually less than 10 per cent of the plasma concentration.

Penicillin is largely secreted by the kidneys, but the percentage recovered in the urine varied from 37 to 99 per cent. After intravenous injection, the urinary excretion was almost complete in one hour. After intramuscular injection the slower absorption was reflected in longer time before the drug was found in the urine. It is not known what happens to that portion of the drug not excreted by the urine.

Following systemic administration penicillin does not readily penetrate the spinal fluid. The injection of 10,000 Florey units intrathecally into a normal individual caused a penicillin concentration in the spinal fluid at six hours of 25 Florey units per cubic centimeter. The level then dropped rather sharply until about the eighteenth hour when it flattened out considerably, reaching its base line in seventy-two hours. In patients with meningitis rather more rapid absorption of penicillin from the spinal fluid was evidenced by the fact that appreciable quantities of the drug were detectable in the blood for some hours after the injection. In all instances the intrathecal injection of penicillin caused an increase in the cell

count of the spinal fluid. This increase only lasted a few days, but this fact must be borne in mind when making intraspinal injections.

The stability of penicillin solutions has increased with a purer product. The manufacturers advise keeping the solution in a refrigerator (under 5 c). Wm. Kirby of San Francisco ran some experiments showing that the potency is maintained at room temperature for seven days. However, it is probably safer to keep the solution in a refrigerator.

In as much as we all have a limited experience with the drug, experience in other fields must be drawn upon. Penicillin is miraculously effective against the gonorrheal urethritis. It was found that small doses of penicillin in combination with moderate doses of sulfathiazole appears to increase the effect of each other against the Neisserian infection. Whether this effect is due to a true synergism between the drugs is not certain. It may be that some of the patients were more easily cured by penicillin, while others were more susceptible to the sulfa drugs. Those who were resistant to the sulfa drug make more rapid progress under the combined therapy than under penicillin alone.*

In the San Diego Naval Hospital a short dosage schedule was found to be just as effective as a longer one. 100,000 units over a fifteen-hour period was consistently curative, giving negative smears in six hours with no apparent relapses.

The U. S. Army Corps reports that 95 per cent of all male patients receiving 80,000 units or more are permanently cured.

Walter Griffey reports a case of gonorrheal urethritis and gonorrheal conjunctivitis with positive smears for the gonococcus in both the eye and the urethra. 25,000 units of penicillin sodium were injected intramuscularly every three hours for a total of ten injections. Hourly smears and cultures from the eye were made. After five hours the eye smears were negative. The urine was free of gonococci in five and one-half hours. The only other medication used was 1 per cent atropine sulfate.

The way gonorrheal urethritis clears up under penicillin is little short of miraculous. Miller and Scott of Chicago report twenty-one cases all cured by penicillin. It made no difference whether they were recent or old cases and treated or untreated. The interval between the onset of the treatment and the first negative culture varied from one to

six hours with an average of three and three-fourth hours.

Two cases were treated by the local injections of penicillin into the urethra but the results were negative. Likewise when the patients did not urinate when under treatment the cure was effected in the same time. This proves that the penicillin is brought to the tissues by the blood stream, not just by the urine flowing over the urethra.

In 1750 cases of gonorrhea reported to the U. S. Navy Bureau of medicine and surgery by sixteen naval hospitals, one course of penicillin produced bacteriological and clinical cures in 97.2 per cent. An additional course of treatment brought the final figure to 99 per cent. The intramuscular route was somewhat better than the intravenous.

Thrombophlebitis of the cavernous sinus was usually a fatal condition prior to the advent of chemotherapy. Today many cures are being reported. MacNeal, Frisbee and Blevins reported forty-five cases of thrombosis of the cavernous sinus, of which fourteen cases survived under bacteriophage therapy alone; 23 died within five days and in eight cases they died after a prolonged illness.

In 1941 Schall reported 3 cases cured with sulfonamide compounds and heparin using from 580,000 units of heparin down to 130,000 units in his last case: 1,000 units of heparin solution being equivalent to 10 mg. of heparin. David Edelson in the April *Archives of Ophthalmology* reports a case of staphylococci thrombosis of the cavernous sinus cured by sulfathiazole and sulfadiazine, with 45 c.c. of heparin 10 mg. or 1,000 units of heparin diluted in 750 c.c. of isotonic solution of sodium chloride.

Major Pyle reports a case of contact dermatitis in the medical officer who had charge of making the various dilutions. The firm producing penicillin report "The mould in growing on this medium produces a number of substances in addition to penicillin and the purification process at present utilized results in a content of penicillin varying between 20 to 40 per cent, the remaining material consists of extractives soluble in organic solvents which occasionally produce urticaria and vary from batch to batch of the material."

A solution of penicillin was found by Robson and Scott to be quite effective in the treatment of experimental eye lesions produced by a very viru-

lent strain of staphylococcus aureus in rabbits. The strain of organisms invariably caused ulceration of the cornea and producing hypopion in some ninety of the cases. Local applications were commenced one hour after inoculation and were continued hourly for forty-eight hours and thereafter at less frequent intervals. The penicillin solution was much more effective than a 30 per cent solution sodium sulfacetamide or a 15 per cent solution of solubilized sulfathiazole.

In meningitis there are conflicting reports. Pilcher and Meacham found little, if any, beneficial effect in experimental staphylococcal meningitis in dogs. This may have been due to inadequate dosage. Following intrathecal administration even in small doses, the mortality rate fell from 93 per cent in control animals to 54 per cent in treated animals.

Col. H. H. Kennedy reports wonderful results in meningitis, starting with intravenous injections, intraspinal once or twice a day for the first two days, then once a day. Intramuscular injections were given every three hours around the clock. He used 100,000 units the first day, 200,000 units in the second twenty-four hours if the case was not responding. One may use 400,000 units per day. Treatment is kept up for five to seven days.

Capt. McCarthy reported seventy-nine cures out of eighty cases of meningitis. As a rule 250,000 units were used. The dark brown penicillin is more irritating and more apt to cause intracranial irritation.

Against pneumococci penicillin is highly successful. Tillett has reported a series of 46 cases of pneumonia, with bacteremia in 14, in which rapid recovery occurred in thirty-nine, death occurred in three cases. The earlier reports of pneumococcal meningitis were not so favorable, only one-third of twenty-one cases recovering. However, with more adequate dosage, a more purified product and intrathecal injections, the rate of recovery was much more favorable.

Penicillin used locally was found effective by Von Sallman in checking experimental intraocular infections in rabbits caused by pneumococci types III, VII, X.

Cashell, in the *British Medical Journal*, March 25, 1944, found good results with penicillin in acute conjunctivitis and blepharitis, chronic blepharitis, infected corneal ulcers, perforating corneal injuries with risk of intraocular infection.

He used it in the form of drops and in an ointment base, 500 units per gram. Irrigations of the anterior chamber were carried out in interior infections. The calcium and sodium salts have been well tolerated in the eyes.

The sodium salts should not be used in the dry state, as they cause considerable pain.

Penicillin is supplied in ampules of 10,000 and 100,000 units each, the larger size being cheaper and preferable. It may be dissolved in normal saline so that the final concentration is 5,000 units per cubic centimeter. It should be stored in the ice box under strict aseptic precautions. It may be given intravenously or intramuscularly or the two may be combined. Continuous intravenous drip is used, 25 to 50 units per c.c., so that 2,000 to 5,000 units are given every hour. Most of the men prefer the intramuscular method, given around the clock, using 15,000 to 25,000 units every three hours.

When injected into the spinal canal 10,000 to 15,000 units diluted in normal saline so that each cubic centimeter contains 1,000 units should be given twice a day. The question of how long treatment should be continued is up to the attending physician. It is better to give too much rather than too little.

Laboratory tests to titrate the inhibiting power of the blood should be used where available.

There is a tendency for staphylococci to develop a fastness to the drug, unless the dosage is adequate. This is more apt to develop in the first week, according to Lyon.

W. E. Herrell reports a dramatic cure of a fulminating cavernous sinus thrombophlebitis in which sulfathiazole and heparin had failed. All cases of extensive cellulitis of the mouth recovered under penicillin.

Hemolytic streptococcal infections are also curable by penicillin although not as many cases have been treated as staphylococci. Some forms are found to be resistant, most commonly in the viridans group. Fleming reveals that following strongly bacteriostatic and retains this power intrathecal injections the spinal fluid becomes for one to four days.

In early syphilis, the use of penicillin is very encouraging, according to Mahoney of the Marine Hospital, Staten Island. The cases treated all received 1,200,000 units. The cases of four recently infected male patients, each with a single penile ulceration showing the treponema pallidum,

were given intragluteal injections of 25,000 units every four hours, night and day, for eight days. After the sixteenth hour of treatment no spinal forms of treponema were seen under Darkfield examination in scrapings from the chancres. Serologically they became negative. Observation of this group of patients is continuing and the results continue encouraging in an increasing series of patients.

Bloomfield and his associates also report good results with penicillin in seven cases of early syphilis. However, these authors stress the fact that it is too early to draw definite conclusions. The general opinion is that penicillin is of value in early syphilis but is not of so much value in later stages.

The Oxford group report cures of conjunctivitis, as does Florey's. A penicillin ointment is made by dissolving the powder in distilled water and incorporating it in vaseline in a strength of 600-800 units per gram. In the majority of the cases treated, the predominating organism was the staphylococcus aureus and a high percentage of cures was effected. Corneal ulceration healed in from five to seven days. One case of gonorrheal ophthalmia neonatorum that resisted the sulfonamides was clinically cured in two days. Blepharitis took from two to twelve weeks for a cure.

My own experience with penicillin has been limited but very interesting.

My first case was a young girl, aged eight years, with a complete atresia of the right nostril. The posterior nares appeared open. She had been operated by another rhinologist, but he was unable to get an opening. I operated her at Grace under ether, cutting the adhesions loose from the septum, so as to leave the cartilagenous septum well covered. There was a bony obstruction that was very dense a little over half way back, which required removal with the Grünwald punch forceps. No opening was made into the ethmoid cells and there was none of the mucoid secretion that is usually present in the congenital posterior obstructions. The parents insisted on taking the patient home the following morning when I saw them at the hospital the evening of the day of the operation. She seemed well so I gave in. However, I did not see her the next morning when I learned later that the right eye was quite swollen. Two days later the father phoned me and said that the child had been perfectly well but became unconscious that morning. I had them bring her into the hospital at once. Her temperature was 107° rectal on admission. She was unconscious and there was a marked neck rigidity and positive Kernig. The right eye was swollen shut, the lids were red and

there was a marked orbital cellulitis. A spinal fluid examination was ordered with instructions to follow the withdrawal of the spinal fluid with an injection of 15,000 units of penicillin intrathecally repeated twice a day. The first spinal fluid showed 600 cells per c.c.m., 80 per cent polymorphonuclear leukocytes, 20 per cent lymphocytes, the fluid clear with a trace of globulin and + albumin. And then came the jolt. The Kahn and Kline were both 4+ positive and the gold curve was also positive. No organisms were found in the smear and the cultures were all negative. She was given one intravenous injection of 25,000 units and then 15,000 units of penicillin intramuscularly every two hours. It is quite remarkable how little the patients object to the intramuscular injections. However, that doesn't go for the intraspinal injections, so after a few shows they were given intraspinally just once a day, then after one week the intrathecal injections were stopped. By this time the spinal fluid was reduced to twenty-nine one day and eighty-four the next day. The intrathecal injections of penicillin raises the cell count so I regarded this count as normal. After three or four days the patient recognized me and called me by name.

She was given a total of 2,500,000 units of penicillin. This child looked terribly sick when first seen, but 600 cells is a very moderate cell count for any meningitis. The orbital cellulitis looked very vicious, but it was not necessary to do any surgical drainage.

She was subsequently given bismuth intramuscularly and later will be given a course of arsenicals by her family physician, who, by the way, had never suspected syphilis in the family. The mother did have a cervical ulceration and her blood was 4+ Kahn and Kline positive.

Vision in the eye is 20/20; there is 1° left hyperphoria and 2° exophoria at the distance. She can move her eyes perfectly in all six cardinal directions. In spite of all the penicillin she still had a positive 4+ reaction.

My second case had a very complicated history. He is a male, aged sixty-seven, an allergic patient, having had hay fever for years with some asthma. He came in February 24, with an injected right eye, a typical acute conjunctivitis with a lot of mucus pus in the eye. He was given zinc sulphate and 10 per cent sulfathiazole ointment. He developed a skin irritation four days later and I suspected an allergic reaction to the sulfathiazole which was stopped. The next day it was quite apparent that he had an erysipelas. This was treated with epsom salts locally, sulfadiazine internally. In the course of two weeks this skin condition cleared up. He then developed an iritis and there were some iritic adhesions. On pushing the atropine he complained that he could not urinate. I suspected a prostate enlargement and wanted it examined. He insisted on going to his family physician who said the prostate was normal. However, two days later he referred him to Dr. Fred Cole who found a very large prostate which he subsequently operated very successfully.

He subsequently had pollen shots for his hay fever. The iritis cleared up but he continued to have a stringy mucous discharge from the conjunctival sac of the right eye. On June 3 he again abraded the cornea of the

eye in his strenuous efforts to clean out mucus from the eye. There were a lot of folds on Descemet's membrane but this cleared up under sulfamerazine and local treatment. However, the ropy discharge continued.

A culture of the conjunctiva showed staphylococcus aureus. I then gave him some penicillin locally but urged that he go to the hospital for a course of treatment with penicillin internally. This was refused. He had an allergic reaction in the lids to the local use of penicillin and then, fearing another attack of erysipelas, you could not keep him out of the hospital. He wanted the treatment at once. I gave him 1,000,000 units intramuscularly, in 20,000 unit doses. That was the end of his conjunctivitis. This case ran from February 24 to August 3, with the conjunctivitis continuing in spite of everything I could think of. He cleared up perfectly under penicillin internally. The pupil dilated perfectly with no adhesions and vision is 20/20, there being some nuclear opacity.

A third case was a conjunctivitis in an old blind eye with dense corneal scars. A hypopion ulcer developed which cleared up under phenol cauterization and sulfadiazine, sulfathiazole ointment, atropine and other local treatment. However, the condition returned. I took him to Grace Hospital and gave him 1,000,000 units of penicillin in 20,000 unit doses every three hours. We used penicillin locally but soon got a marked eruption of the lids and had to stop it. I could see no benefit from the penicillin.

Subsequently he had all his teeth out and a vaccine made from the infecting organisms did him a lot of good. However, it remains to be seen how long this old blind eye will remain quiet. In other words, my lesson from this case is that penicillin is not a cure-all and infections must be removed.

My next case to report is a case of sympathetic ophthalmia in a woman, aged sixty-two, who had a cataract extraction up in the state. The eye developed considerable reaction in the cornea, exudate in the aqueous and circum corneal injection. Subsequently she developed a sympathetic ophthalmia in the second eye. There were large K.P. spots on the posterior corneal wall, No. 3 specks floating in the aqueous humor and the lens. There was a secondary increased tension. The jaws were edentulous. An x-ray showed no retained roots, and the sinuses were clear. There was a well advanced central nuclear cataract.

She was hospitalized and given penicillin, 20,000 units intramuscularly every three hours for a total of 2,000,000 units. There was considerable improvement in her ocular condition, but there were still some floaters in the aqueous and the K.P. remained although I believe they were smaller. Vision improved but declined when the tension again went up. Paracentesis of the cornea will be necessary. It is too early to evaluate the effect of penicillin in this case. My impression is that she was improved, but by no means cured.

My last case was a recurrent case of iritis. This

patient had been thoroughly checked at the Mayo Clinic and at Ann Arbor. All that could be found was an arthritis of the spine. There was some decay under a filling in a lower incisor but otherwise the teeth were negative. His brother-in-law had started him on penicillin before I was called in. I could see no particular benefit from the penicillin in this case. I can get much better results with sulfadiazine. However, the removal of foci of infection gives still better results in cases of iritis.

Conclusions

My results with this wonder drug show that in selected cases it is really miraculous. However, it is no substitute for an accurate diagnosis. In orbital cellulitis, thrombophlebitis and meningitis it surpasses expectations. In uveitis it does not seem to be of much value. In conjunctivitis of a stubborn nature it certainly is worthy of a trial. My very limited experience with its local use showed that it is apt to develop a dermatitis of the eyelids. However it has been successfully used by many in blepharitis and conjunctivitis. To date no firm I am familiar with makes an ointment that retains its potency. This must be made up by your pharmacist.

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Spontaneous Hypoglycemia

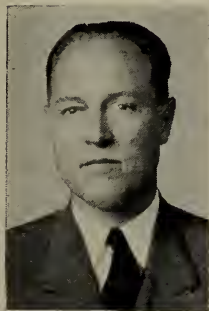
A Case History

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It is very important to be familiar with the symptom complex presented by the group of Spontaneous Hypoglycemias and the pathologic physiology underlying them in order to be able to arrive at an etiologic diagnosis in each case. A most interesting case history is presented which illustrates one of the types and a plan of procedure is outlined to differentiate the various types and suggestions made for the Medical management of the case presented.

- THE case which we are presenting belongs to the group of spontaneous hypoglycemias and of-

fers a problem in the differentiation of their etiology. The history shows some very interesting facts and draws attention to a symptom complex which we will do well to bear in mind continually. It is most important to determine the etiology of these cases in order to apply the proper treatment to any individual case.

Case Report

The patient, a thirty-six-year-old white man, was admitted to the Mt. Carmel Mercy Hospital through the emergency room with a superficial laceration of the left upper eyelid. When first seen, he was standing, and was swaying as if mildly intoxicated. However, he had partaken of no intoxicating beverages for some time. During the suturing of his eyelid, he repeatedly complained of extreme weakness and fatigue. He said he had retired about 11:00 P.M., slept for one hour, and then had arisen to go to the bathroom. While on the way, he suddenly felt weak and fell to the floor unconscious. While in this state he voided. His wife who heard him fall, said he was unconscious for about five minutes, during which time he lay motionless. Apparently, he regained consciousness spontaneously, after which he felt very weak. He then came to the Hospital for treatment of the eyelid, which was injured in his fall.

The patient stated that he has been having these weak spells for the past three years. Their occurrence was, at first, about one week apart, but they had become progressively more frequent until for the past six months they occurred almost daily. These spells were described as "waves of weakness, fatigue and giddiness." True vertigo was never experienced. During these attacks, the patient frequently would feel cold and clammy. The attacks practically always occurred in the morning after breakfast. The exact time interval could not be ascertained, but was about one to one and one-half hours after breakfast. They never occurred prior to breakfast, despite the fact that many times breakfast was delayed. The patient offered the information that, frequently, at the onset of an attack he would stop whatever he was doing, and eat a candy bar or piece of pie or cake. This always afforded relief from the distressing symptoms. He never lost consciousness, however, before the attack which led to his admission to the hospital. There were no apparent sequelae. He was discharged from the U. S. Marine Corps at the age of twenty-four, because of "extremely high blood pressure." He states that he had high blood pressure as recently as five years ago. The patient had been working fifteen or sixteen hours a day for the past few years. However, he has had to decrease this in the past few months because of his illness. His type of work was executive, but occasionally involved heavy work. There were no other significant points in the patient's past history. There was nothing clinically significant revealed by examination of the various systems.

The patient appeared to be a well-developed, and

well-nourished man, not acutely ill. The pulse rate was 76, regular, and of good quality. The blood pressure was 130 systolic, 90 diastolic. Temperature 98.6. Respiration 19.

Eyes: the pupils were round and equal, and reacted well to light and accommodation. Fundoscopic examination showed: normal disc, arterio-venous nicking, increased arterial light reflex, arterio-venous ratio of three to one, no hemorrhages, petechiae, or exudate.

There were no apparent abnormalities of the ears, nose, mouth, throat, or neck. The heart, lungs, and abdomen were normal in all respects, as were the extremities. The skin was devoid of pathology except for a small papular eruption which had been present for several years.

Laboratory Findings: Complete Blood Counts were done on April 27 and April 29, 1944, and were both found to be normal.

Urinalysis: Specific gravity 1.028, negative for pathologic findings.

Fasting Blood Sugar: April 28, 1944—86 Mgm. per cent.

Glucose Tolerance Test:

	April 28, 1944	May 1, 1944	May 3, 1944
Fasting	81	74	84
½ hour	153	150	182
1 hour	207	124	148
2 hours	171	106	108
3 hours	68	92	75
4 hours	36*	76	74
5 hours	52	79†	78
6 hours	—	96	—

*At the time blood was drawn for this sample, the patient complained that he was having a typical attack of weakness as described in the history above.

†Patient given 1 c.c. of adrenalin to note effect on blood sugar level.

X-ray examination of the chest showed an old calcified lesion in the left apex. Otherwise it was negative. That of the skull showed no pathology involving the Sella Turcica.

A flat plate of abdomen revealed no calcifications in the suprarenal areas.

The patient's stay in the hospital was uneventful except for the typical symptoms experienced during the first glucose tolerance test. These symptoms did not recur during the two subsequent tests. A discussion concerning this fact will be found later in the paper.

A diagnosis of functional hypoglycemia was made and the patient was discharged and put on the following regime: 1860 caloric diet of high protein type; 150 gms. of CHO; 90 gms. of protein; 100 gms. of fat. Regular mealtimes; regular sleeping hours; vitamin B-1 by mouth. Patient instructed to drink a two-egg eggnog before retiring. This was in addition to the above diet.

It has been six months since this patient was discharged, and he has had only one recurrence of weakness. This occurred while he was doing muscular work, which tends to stimulate insulin production and deplete the body carbohydrates. The patient says that he feels bet-

ter than he has in several years, and has gained ten pounds in the past six months. He has been free of distressing symptoms except for the one special occasion noted above.

Discussion

It is not our intention in this paper to go into all of the intricacies of carbohydrate metabolism, many of which are not fully understood, nor to discuss all of the types of hypoglycemia, but rather to re-emphasize a plan of procedure, by which a case of hypoglycemia may be classified as regards etiology.

The discovery of insulin in 1922 by Banting and Best gave an opportunity for the study of the symptoms of hypoglycemia resulting from the giving of an overdose of insulin (exogenous) and a correlation of these with the similar symptom complex produced by endogenous causes.

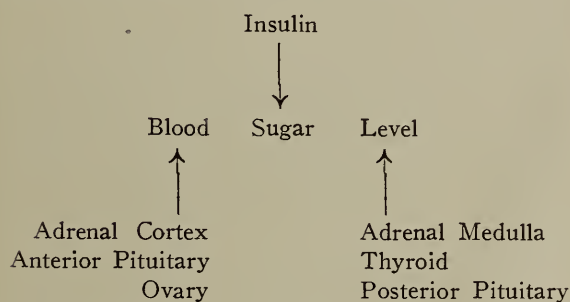
The symptoms, regardless of their etiology, are very characteristic as exemplified by this case and vary with the degree of hypoglycemia. The principal ones are weakness, nervousness, hunger, palpitation, sweating, visual disturbances, and mental confusion and in the more severe cases include vomiting, diplopia, convulsions, coma, and death. These symptoms are found to be associated with a very low blood sugar and are dramatically relieved by the administration of glucose.

The symptomatology of hypoglycemia has as its basis the lowered metabolism of the brain. As is well known, the brain derives its energy almost entirely from the oxidation of glucose, in contrast to most other tissues which may also metabolize fat for energy. Thus, as hypoglycemia occurs, brain metabolism decreases, due to lack of available glucose; then the chain of symptoms begins. Because the higher centers of the cortex are affected first, there develop anxiety, mental retardation, sweating, muscle weakness, tremors; loss of consciousness and muscle spasms may follow. The medulla is the last center involved and here vital functions such as respiration are affected. The mechanisms whereby hypoglycemia causes death and the action of glucose in producing restoration remain only partially solved. It has been shown experimentally in dehepatized animals in which hypoglycemia was recognized as the cause of death, that respiration always stopped before the heart and that artificial respiration will prolong life. All the major symptoms that appear in hypoglycemia are due to

functional alterations in the central nervous system. The discernible effect of glucose is to restore function to the brain, which requires mainly glucose to carry on its metabolism.

As is true of so many of the functions of the body, the blood sugar level is regulated by two opposing systems, one of which tends to elevate it, namely, the para-sympathetic insulin system and the other which tends to lower the blood sugar, namely, the sympathetico-adrenal system. There are many complex features influencing each of these systems. However a delicate adjustment between them results in a normal blood sugar level. The newer concepts of diabetes as shown by Conn, indicate what a powerful influence the pituitary, thyroid and adrenal have in elevating the blood sugar level and counterbalancing the hypoglycemic tendency of insulin.

Graphically this system of checks and balances might be diagrammed as follows:



In this diagram it will be seen that the effect of insulin is to lower the blood sugar level, while that of the glands listed below tend to elevate this level. There are, of course, many other factors which influence the end results. There are a host of etiologic factors which may contribute to hypoglycemia, which we list as follows:

ETIOLOGIC CLASSIFICATION OF SPONTANEOUS HYPOGLYCEMIA (CONN)

1. ORGANIC: Recognizable anatomic lesion
 - (a) Hyperinsulinism
 - (1) Pancreatic island cell carcinoma
 - (2) Pancreatic island cell adenoma
 - (3) Generalized hypertrophy and hyperplasia of islets of Langerhans
 - (b) Hepatic Disease
 - (1) Ascending infectious cholangiolitis
 - (2) Toxic hepatitis
 - (3) Diffuse carcinomatosis
 - (4) Fatty degeneration
 - (5) Glycogenosis (Von Gurke Disease)
 - (c) Pituitary hypofunction (anterior lobe)
 - (1) Destructive lesions (tumors, cysts)
 - (2) Atrophy and degeneration (Simmonds disease)
 - (3) Thyroid hypofunction (secondary to pituitary)

- (d) Adrenal hypofunction (cortex)
 - (1) Idiopathic cortical atrophy
 - (2) Destructive infectious granulomas
 - (3) Destructive neoplasms
- (e) Central nervous system lesions of brain and brain stem.
2. FUNCTIONAL: No recognized anatomic lesion
 - (a) Hyperinsulinism (anatomic nervous system imbalance)
 - (b) Renal glycosuria (Low renal threshold for dextrose)
 - (c) Severe continuous muscular work
 - (d) Pregnancy and lactation

Of all these listed above, the commonest types seen fall into three classes: (1) organic hyperinsulinism, (2) liver disease, and (3) functional hyperinsulinism or failure of the neuroendocrine system.

Of these, the first two are organic, while the latter is functional in nature.

It has been estimated by Wilder and others that 80 to 90 per cent of all cases of spontaneous hypoglycemia fall into one of these three groups and of these by far the largest is that of functional hyperinsulinism.

Also, in classifying hypoglycemia from a point of view of the clinical behaviour, the various etiologic types may be divided into two broad groups, namely, the stimulative hypoglycemias and the fasting hypoglycemias.

Functional hypoglycemia is one of the stimulative types while the organic types (hepatic and true hyperinsulinism) belong to the latter group.

The principal problem appears then to differentiate between organic and functional hypoglycemia. In arriving at such a differentiation, the following are important aids in an etiologic diagnosis, according to Conn.

1. THE FASTING BLOOD SUGAR.—When the previous diet has been normal a depression of the postabsorptive blood sugar value (taken before breakfast) below fifty mgms. per cent means organic hypoglycemia with few exceptions. Functional hypoglycemia is not associated with low levels of fasting blood sugar. This is an important differential point. It may be noted that in our case the fasting blood sugar was not abnormally low.

2. DEXTROSE TOLERANCE TESTS.—When these are preceded by a standard preparatory diet containing 300 gms. of carbohydrate, they show, in liver disease, a high plateau type of glucose tolerance curve, similar to that seen in diabetes mellitus, with the exception that the fasting level is usually abnormally low.

3. TESTS OF LIVER FUNCTION.—Multiple tests are recommended inasmuch as one function may be damaged while others are unimpaired.

4. CLINICAL TEST.—In organic types the disease tends

to progress and get worse. The functional types show periods of severity alternating with remissions and attacks are of short duration and clear spontaneously.

5. RESPONSE TO INSULIN AND EPINEPHRINE.—The former is of very little value but the latter may help to differentiate the hepatic type.

In the case presented we can rule out as etiologic factors organic hyperinsulinism and liver disease. There is nothing in the history or examination to indicate severe liver pathology. The glucose tolerance curves are not those seen in liver disease. The patient was not suffering from organic hyperinsulinism because the fasting blood sugar was not low and the glucose tolerance curve was not that of a hyperinsulinism. Thus, the patient's hypoglycemia must be due to a defect in the neuro-endocrine system, and is therefore functional; however, by a process of elimination organic involvement of any of the endocrine glands may be ruled out as follows:

PITUITARY GLAND

1. There is no evidence of pathology in sella turcica;
2. There is no evidence of anterior pituitary defect;
3. There is no evidence of posterior pituitary defect and if present alone, it probably would not cause hypoglycemia severe enough to produce symptoms.

ADRENAL CORTEX

1. The patient's hypoglycemia is not constant
2. Fasting blood sugar is not low
3. The patient proves he can convert protein to carbohydrate by therapeutic test
4. No other evidence of adrenal cortex involvement is present and hypoglycemia in adrenal cortex insufficiency occurs usually only in the severe cases with crisis.

ADRENAL MEDULLA

1. Usually fatal if involved organically to any significant degree

THYROID GLAND

1. There is no clinical evidence of dysfunction of this gland

There are several points of interest in regard to the case presented which should be discussed. First of all, there is no definite evidence that the patient has any organic pathology involving the organs concerned with blood glucose metabolism. The patient does not present a psychoneurotic picture. He did not have false attacks of symptoms, when hypoglycemia did not occur. However, when hypoglycemia did occur, the patient had an attack with the typical symptoms of which he complained. Thus we may draw the conclusion that this patient's symptoms were positively due to hypoglycemia; also, that this state is not associated with organic pathology determinable at our present level of knowledge and understanding.

Another significant point is that hypoglycemia

did not always occur following a carbohydrate meal. This would tend to support the view that organic pathology is not a factor here. This variation in reaction would fit in with a functional disturbance. A factor that cannot be ignored is the poor hygienic life which this man was living. He was working very long hours in a job of responsibility, eating irregularly and poorly, and his sleeping habits were faulty. The first glucose tolerance test has already been pointed out. This was done on the day after admission. In contrast to this, glucose tolerance tests three and five days after admission failed to show the typical hypoglycemia. It must be remembered that during these hospital days, the patient was eating balanced meals at regular hours, resting, and sleeping regularly. Apparently, then, a part of this man's illness may have been caused by poor living habits. However, there are thousands of persons with as poor living habits who do not develop hypoglycemia, but in this case they appear to be a contributing factor.

One thing which is very difficult to explain is the lack of hypertension, despite a definite history of same and a Grade II retinopathy at the age of thirty-six. However, since the etiology of hypertension is unknown, it is impossible to evaluate this factor.

A very important point is that this patient responded immediately to the therapy instituted. He has remained symptom-free for six months, except for the incident noted.

In conclusion, therefore, it may be stated that this patient has a functional imbalance of the neuro-endocrine control of blood sugar metabolism, resulting in states of spontaneous hypoglycemia. The patient has been rendered symptom-free for a period of six months by means of a high protein diet and a hygienic mode of living.

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Michigan Medical Foundation

The Michigan State Medical Society has created the "Michigan Foundation for Medical and Health Education" based on the carefully considered pattern developed by the Postgraduate Foundation Committee. Months of detailed study preceded final approval of the project and incorporation of the Foundation to perpetuate health education in this State.

The purposes of the Foundation graphically illustrate the broad scope of the State Society's latest progressive venture: "To acquire, provide, use, develop, endow, and finance methods, means and facilities for postgraduate education in medicine, for education in medicine, for lay health education, and for research, fellowships, and scholarships."

Any high-minded activity, designed to benefit the public, deserves the support of the medical profession. But when that movement benefits the people through the aegis of the medical man alone, then his responsibility to support the work is real and great. The individual Doctor of Medicine—every member of the Michigan State Medical Society—owes something and usually much to the noble profession which has brought him gratifying rewards for oft-times arduous but ever-stimulating service. No greater self-satisfaction can be achieved by a physician than by contributing some portion of that reward towards the preservation of the profession he loves. I earnestly recommend the Michigan Foundation for Medical and Health Education to the consideration of our doctors who personally or through influence with patients and friends are able financially to help build this monument to Michigan Medicine.



President, Michigan State Medical Society



President's



Page



Editorial

WHERE DOES IT LEAD?

IN JUNE, 1943, in an editorial of this same title, we told of the fund of \$37,000 made available in Michigan by the Children's Bureau of the Department of Labor, offering maternity and infant care to the wives and children of enlisted men of the armed forces. This was a part of a general appropriation of \$1,200,000. We made two comments that we now repeat:

"This is only obstetrics and pediatrics. What is to prevent the Department from including care for any illness or any surgery, or eye, ear, nose and throat next month, or next year?"

"We are told this is temporary, for the duration of the war and six months after, but nothing is so permanent as a temporary expedient. Soldiers' wives will then be veterans' wives."

Where has it led? Read the following from the *New York Times*:

"The Congress of Industrial Organizations asked, March 25, that the emergency maternity and infant program be extended to cover wives and widows of veterans, and infants born after the father leaves the service. Limitation of the program to wives of enlisted men of the lower four grades is working hardships on many families, Philip Murray, President of the CIO wrote Representative Butler Hare, Chairman of a House subcommittee considering renewal of the program. Asking wide extension of the benefits, Mr. Murray said the wives of veterans should have assistance for two years after their husbands are discharged." (*New York Times*, March 26, 1945.)

"A national plan for maternal and child health, to include financial provisions to provide adequate clinical and hospital service to mothers, infants and children as part of the community health service has been adopted by the steering committee on health services of the Children's Bureau." (*New York Times*, Feb. 24, 1945.)

The committee made eight recommendations including the following:

"1. Increase Federal grants under the social security system for maternal and child health and crippled children's services.

"2. Extension of such services in the states to cover the entire population.

"3. Health services for mothers and children of all ages to include periodic health examinations, medical care when needed, dental care and mental hygiene.

"4. Extension of service for crippled children to include rheumatic fever, and special centers for training of those afflicted; and all other handicapping conditions such as visual and hearing defects, diabetes or other chronic diseases." (*New York Times*, Feb. 24, 1945.) (Italics ours, Editor.)

We still believe as we have stated so many times that all Federal bureaus will bear watching that Federalizing of medical practice is still a threat, and that only by eternal vigilance and aggressive action may it be stayed.

MEDICAL HONESTY

THE *Saturday Evening Post* on May 19, 1945, published an editorial, "Everybody Knew It But the People," calling attention to the state of the President's health during the last presidential election. The politicians, according to Walter Lippmann, knew they were electing a new president, but everyone who asked about the president's health was branded as conducting a whispering campaign. Admiral Ross T. McIntire, the president's physician, stated he was "in better physical condition than the average man of his age, that his health was good, very good, that he was in splendid shape."

The *Post* gives as a reason for bringing this up that it must not happen again. We bring it up to ask a question: How far may a doctor of medicine go in falsifying the facts when giving a report on the condition of his patient, upon whose health great questions hinge? Admiral McIntire may have known the true condition of his patient. If he did, and issued misleading reports, he placed the medical profession in a bad light.

Mr. John F. Hunt, in the survey of public opinion held in Michigan, told us that a small percentage of the people believe that doctors are not honest. How right was he? Do doctors make such forecasts with impunity?

The condition of the President's health is a matter of justifiable concern to each of us. We should be assured that a candidate for such an important office is in reasonably good health. We require officers of the Army and Navy to stand a physical examination before accepting a higher

rank. Why not make the same demand on the "Commander in Chief" while he is a candidate?

MEDICAL OFFICERS AND THE VETERANS' ADMINISTRATION

Government by Directive

THE MICHIGAN State Medical Society has received a letter from one of its members, whose name obviously must be withheld, reading in part as follows:

"I have a problem which also involves a few hundred other army doctors. In my case, I volunteered for service in the Army Medical Corps, and when [I became] surplus in the Army I was assigned to the Veterans' Bureau. I figure, and I believe rightly, that when surplus in the Army at my age, I am entitled to retirement. Have so protested but request was denied, the head of the S.G.O. personnel section stating, 'Assignment to Veterans' Bureau for duty is considered as essential military duty.'

"I don't agree that I volunteered to serve in a Veterans' Bureau. I want to know who does the considering? Is this assignment valid under the laws, or merely a sayso by some Washington Bureaucrat?

"The so-called scarcity of doctors in the Veterans' Bureau is due to several things: (1) poor remuneration; (2) cavalier treatment of M.D.'s by the autocrats; (3) loss of M.D.'s due to movement into civil practice when fellows such as the writer moved to the Army.

"I cannot conceive that my volunteering for army service should be so penalized. Such an act constitutes virtual enslavement. What will be the end to the construance as to what constitutes military necessity? I am just 'plain wound up' over this. . . . I don't know how many Michigan doctors are so involved, but there are several hundred so shanghaied in the United States."

We have noted that the commissions of the Army medical officers all read "for the duration of the war, and six months." In the Navy it is "at the pleasure of the President." In either case, transfer from one service to another was never considered until some months ago when a directive was issued (the reference not now available), allowing transfer, on necessity, of officers between the two major services, and the United States Public Health Service; later the Veterans' Administration was added.

This matter of transfer of medical officers to other services, and especially the Veterans' Administration is not confined to one doctor in Mich-

igan. The following is quoted from the *Journal of the AMA*, May 19, 1945:

"In November, 1944, the Army Medical Department was directed to transfer at least 300 medical corps officers to the Veterans' Administration, this number to include those officers in the zone of the interior who were formerly employed by the Veterans' Administration as civilians. Apparently, about 100 men meeting the latter classification were so assigned and in addition some 200 others selected largely from among men who had been marked 'limited service.' Many of those thus assigned have protested and others are now protesting bitterly against these assignments on the ground that their enlistment was distinctly for military service and that assignment to the Veterans' Administration cannot be thus characterized. Many physicians who have served with distinction in both the European and the Pacific theaters of operation are now indicating by communications addressed to the headquarters of the American Medical Association *the fear that they may be assigned* on their return to the United States to service with the Veterans' Administration. The unwillingness to serve with the Veterans' Administration is based not only on their belief that this cannot be considered military service but also on the point of view that competent, scientific medical care is difficult under the conditions that prevail in the veterans' hospitals."

Bureaucrats have not responded in other matters to storms of protest. But Medical Officers may respond to a protesting avalanche from our members and the many patients who may want their own doctors back in the near future. As matters now stand, these doctors may be retained in the Veterans' Administration for the duration and six months. When will the "duration" end?

"FOR THE DURATION"

FOR THE duration and six months has entered into so many programs, such as EMIC, and the terms of service of the army personnel, that we have attempted to evaluate just what it means. Of course the duration means the duration of the war. And that does not mean an armistice, it means the acceptance of terms and the promulgation of peace. After the first World War the treaty of peace was signed June 28, 1919, and promulgated January 10, 1920. The United States failed to ratify, and made a separate treaty in 1922. We are unable to find the date in any available reference. The duration so far as Europe was concerned was fourteen months af-

ter the armistice. For the United States it was at least thirty-eight months. The same could hold for this present war.

VETERANS' MEDICAL CARE

MORE AND MORE the Veterans' Administration comes to the fore. The latest is the appointment of General Omar Bradley to head the organization. Being a veteran of this war, he will understand the wants of the newer veterans, and naturally will try to supply them.

The Bureau has received much unfavorable comment because of its so-called inadequate or antiquated medical service. Much of the criticism is probably unnecessarily harsh, but it indicates a lack that must be remedied. We suggested in February (page 172), "that authorization be made at once for the use of private hospitals and care by private physicians." There are many "Veterans' Administration Facility" hospitals throughout the country, and additions to them are in process of construction. This construction was stopped for a time, but has just been resumed, at least in the Fort Custer Facility. The construction of new buildings, or new facilities with the \$500,000,000 made available does not care for the present need, which is a real need. Men are returning to civil life at an ever-increasing rate. The prime reasons for their return to civil life are their incapacities which do now and will in the future demand medical attention.

The Michigan State Medical Society, through its Council,* has proposed that care by the home physician be authorized to meet this emergency, and to care for the increasing needs until other arrangements may be made. The Veterans' Administration has been unsuccessful in obtaining enough medical officers and has recently proposed the establishment of a medical service somewhat on the order of the Army and Navy or the Public Health Service—that is, a commissioned staff. In the meantime, hundreds of Commissioned Officers of the Army have been transferred under directive to this work. These men volunteered for Army service during the war, and naturally believe they have been unfairly treated. So do we.

*Motion that the reference committee approve the care of Veterans in their home communities by their family physicians was carried unanimously.—Minutes of the Annual Meeting of the Council, January 26, 1945.

Col. J. W. Mountain and others of the United States Public Health Service came to Detroit in May and consulted representatives of the Michigan State Medical Society concerning Michigan Medical Service and how it is working. He asked questions to ascertain whether increased activities could be taken on by Michigan Medical Service and Michigan Hospital Service. One of his questions was, "Could we render services to the veterans of this war? Could we take on large new groups?" He was told the Services could take on that added work and more without a ripple; we have already taken on huge additions and successfully carried on; we believe that voluntary service plans are the best solution to the veterans' problem, the indigent, the border line case, as well as the individual who can and does subscribe to his prepayment medical service needs.

Present Veterans' Administration plans call for hundreds of millions of dollars and years to build hospitals, and additional scores of millions to maintain them. Why not give the returning veteran the *best* medical care *as soon as he needs it*? How? By giving the Veterans' Administration the added authority (if the Administration needs it) to refer all veterans for medical and surgical care *to their own civilian doctors*. The present facility hospitals are full. This would provide for the care now so urgently needed.

The end result! The patient will be far better satisfied; the taxpayer will not have to pay the outlay for great institutions (neither their construction nor their maintenance), and the benefits of the service will include a lessening of the period of illness and convalescence, the natural result of care at home, in home hospitals and among friends. This again will decrease the cost to the taxpayer.

The greatest value of this plan is that it can be put into operation immediately. **USE CIVILIAN FACILITIES FOR VETERANS, IN THEIR OWN HOME TOWNS.** If anyone has earned the right to home treatment and home accommodations, it is the veteran.

This solution is so simple we fear it has escaped the attention of those in authority. Most vexing problems when solved are solved so simply that we wonder we did not think of it before.

RHEUMATIC FEVER

Recognizing that rheumatic fever in childhood is a grave, but common disease the Michigan State Medical Society appointed a special Rheumatic Fever Committee to study and make suggestions to control the disease, and if possible minimize its serious results. This is a novel but practical and timely work. We have invited H. H. Riecker, M.D., to give us editorial comment.*

—EDITOR.

THE DRAFT examinations have brought into bold relief the general incidence of rheumatic heart disease and, in turn, have stimulated both research and programs of control of a disease affecting about two per cent of the school children in the northern states. The incidence of acute rheumatic fever in the Army of three cases per each one thousand troops again has stimulated an interest in the control of the disease.

While the etiology of rheumatic fever is not definitely known most of the cases follow an upper respiratory tract infection by the beta hemolytic streptococcus. The onset of rheumatic fever occurs about 10 days following the subsidence of the premonitory infection.

No attempt can be made here to give an adequate discussion of any phase of the disease, but by further study the practising physician should be as familiar with it as he is with acute appendicitis.

Since the etiology is unknown, methods of diagnosis are based upon clinical impressions and in many instances the differential diagnosis becomes extremely difficult. It is hoped, therefore, that the diagnostic centers being established by the Michigan State Medical Society will be freely used by all physicians.

In the presence of fever, joint pain, leukocytosis, an elevated sedimentation rate, and evidence of endocarditis, the diagnosis is not difficult. A child, however, may have only fatigue, mild anemia and epistaxis by which to direct one to a very thorough examination of the heart, where a rapid rate, overactivity and soft systolic murmur at the apex may establish the diagnosis of rheumatic fever. The presystolic murmur of mitral stenosis is diagnostic but the early active disease frequently occurs in the absence of this finding.

Only by having the disease constantly in mind for all age groups does the physician diagnose active rheumatic fever. In some instances the disease is outspoken in its manifestations while in others it is extremely insidious. Unlike the diagnostic facilities for tuberculosis there is no instrument comparable to the x-ray with which to detect early or incipient rheumatic fever.

Rheumatic fever has many similarities to tuberculosis in both its clinical picture and its treatment. Both diseases tend to occur in families, among those crowded together, and in the lower economic levels. Both are characterized by recrudescences. Both may lead to serious crippling or complete and permanent inactivity. Both require long periods of rest and close professional observation.

The treatment of rheumatic fever remains much the same as when MacLagan described the specific action of the salicylic group of drugs in 1876. Sodium salicylate is now preferred and is used both by mouth and as retention enemas, but should not be given intravenously. The therapeutic and toxic doses are close in margin and the physician should be familiar with toxic manifestations of the drug.

The dosage of sodium salicylate varies with the weight of the individual, the adult requiring 240 grains per day for the first few days followed by 120 grains per day for a week, and then gradually decreasing doses until the arthralgia and fever subside. For small children either all or part of the dosage may be given as retention enemas in a two per cent solution of starch water. The enteric coated tablet may be used but if not available, sodium bicarbonate in doses of one-half the amount of sodium salicylate will help prevent gastric irritation. However, the use of sodium bicarbonate seems to lessen the effectiveness of sodium salicylate. In all acute cases the patient should be strictly at rest in bed. The affected joints may be painted with methyl salicylate and covered with cotton or woolen flannel. The pyrexia of rheumatic fever is higher than in almost any other disease and an adequate fluid, caloric and vitamin intake is particularly necessary. Salicylic poisoning rarely occurs. Its features are those of an acidosis. This complication is treated by the intravenous use of appropriate amounts of sodium lactate (Hartman's solution).

Penicillin and the sulfonamides have no value in the active stage of rheumatic fever and may

*For outline of study see report of Child Welfare Committee on Page 743.

be harmful. It is particularly desirable not to use a sulfonamide during the course of the disease nor until all signs of activity have ceased, since under the latter circumstance a recrudescence may take place.

The rest regimen should be enforced until the heart rate, fever, and sedimentation rate are normal. There is danger also of producing a recrudescence by such operations as tooth extraction, sinus operation, or tonsillectomy. However, should such procedure be necessary the sulfonamides should be exhibited adequately, risking the flare-up of rheumatism to avoid subacute bacterial endocarditis.

Having carried a child through a course of rheumatic fever the problem of preventing recurrence becomes the physician's next responsibility. After all signs of activity of infection have disappeared, a further delay of about six weeks is followed by the use of a sulfonamide in doses of one to one-and-one-half grams a day, depending somewhat on the size of the child. Either sulfadiazine or sulfamerazine is valuable for this purpose. If there are renal complications sulfanilamide is preferable. The dosage of sulfanilamide for younger children is five grains three times a day, and for older children ten grains with the morning and evening meals. If the child weighs around 50 pounds, 30 grains a day is an adequate dosage. The dosage of sulfamerazine is between 3 and 7 grains once a day for the majority of children. One of these drugs should be given continuously throughout the year to the child having recovered from rheumatic fever for as long as five years.

Adequate blood levels apparently have nothing to do with the prevention of recrudescences. Any toxic effects of the drug are most likely to appear during the first twenty-one days and after this, check-ups of the white cells should be made once a month. There is no verified instance of agranulocytosis after forty-eight days of continuous use of these sulfonamides in small doses. In children under ten years of age who have had several attacks with pronounced cardiac damage a sulfonamide might be used with advantage for eight or ten years.

No doubt the intensified research in the numerous problems of rheumatic fever will bring better methods of management and prophylaxis.

so that all physicians should keep abreast of progress in this widespread and crippling disease.—
H. H. RIECKER, M.D.

ON THE RUN . . .

As chronic nephritis progresses towards terminus, the formed elements in the sediment (such as casts) usually diminish or even disappear.

• • •

A normal parathyroid gland is three quarters fat and one quarter epithelial cells, whereas a tumor is made up entirely of epithelial cells. Hence the difference in color.

• • •

Marked obesity, severe cardiac or respiratory disease, esophageal lesions and deformities of the spine are contraindications to gastroscopy.

• • •

Calcium deposits in the kidney, when not due to infection, result either from injection of too much calcium, or too much alkali, or a blood acidosis, or hyperparathyroidism.

• • •

Symptoms are produced by cervical ribs in less than half of those showing this anomaly.

Selected by W. S. REVENO, M.D.

PENICILLIN IN TREATMENT OF PERITONITIS

1. Massive doses of penicillin exert a striking effect on peritonitis and, if maintained for a considerable period of time, will usually effect a resolution of intraperitoneal inflammatory masses.

2. Thirty patients with established peritonitis, intra-abdominal inflammatory masses, or extensive contamination of the peritoneal cavity from ruptured abscesses were treated with 100,000 units of penicillin every two hours intramuscularly for two days and with diminishing doses for six more days. None developed intraperitoneal abscess or complications.

3. If symptoms and signs of intraperitoneal inflammation recur after the first course of treatment, a second course will probably again control the infection.—George Crile, Jr., *Cleveland Clinic Quarterly*—July, 1945.

Michigan State Medical Society

Roster 1945

[An "M" following a name indicates active military service; "E" indicates Emeritus Members; "R" indicates Retired Members; all others are Active Members]

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Burdick, G. J.....Fennville
Dickinson, C. A.....Wayland
Dolfin, W. E.....M

Flinn, C. C.....Allegan
Hudnutt, Orrin Dean.....Plainwell
Johnson, E. B.....Allegan
Johnson, H. H.....Martin
Mahon, James E.....Allegan
Medill, W. C.....Plainwell
Ramseyer, Gladwin E.....Plainwell

Rigterink, Geo. H.....Hamilton
Stuch, Howard T.....Allegan
Stuck, Olin H.....Otsego
Ten Pas, Henry W.....Hamilton
Van Ness, J. H.....Allegan
Vaughan, W. R.....Plainwell
Van Der Kolk, Bert.....Hopkins

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Constantine, Aeneas.....Harrisville
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McIntyre, K. S.....M
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Ziliak, A. L.....Bay City

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Anderson, Bertha.....St. Joseph
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Brown, F. W.....Watervleit
Brown, G. W.....Buchanan
Brown, Rolland J.....M
Burrell, H. J.....Benton Harbor
Cawthorne, H. J.....Benton Harbor
Conybeare, R. C.....Benton Harbor
Crowell, Richard.....M
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Gillette, Clarence H.....Niles

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Gunn, J. W.....Watervleit
Hanna, P. G.....St. Joseph
Harper, Ina.....Benton Harbor
Harrison, L. L.....Niles
Hart, Russell T.....Niles
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Kling, H. C.....Niles
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Rosenberry, A. A.....Benton Harbor
Ruth, J. Griswold.....M
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Smith, W. A.....Berrien Springs
Sowers, Bouton.....M
Strayer, J. C.....Buchanan
Thorup, Don W.....Benton Harbor
Waterson, Roy S.....Niles
Westervelt, H. O.....Benton Harbor
Winter, Joseph A.....St. Joseph
Yeomans, T. G.....St. Joseph

ROSTER 1945

Branch County

Andrews, Frank A.....Coldwater
Bailey, J. E.....Coldwater
Beck, Perry C.....Bronson
Bien, W. J.....Coldwater
Chipman, E. M.....M
Culver, Bert W.....Coldwater
Eberhart, L. L.....Coldwater
Far, S. E.....Quincy

Fraser, R. J.....M
Joerin, William.....M
McLain, R. W.....Jackson
Meier, H. J.....M
Mooi, H. R.....Union City
Olmstead, Kenneth L.....M
Phillips, F. L.....Bronson
Rees, Kendall B.....Dowling
Rennell, E. J.....Coldwater

Schultz, Samuel.....Coldwater
Scovill, H. A.....M
Smith, L. Lloyd.....M
Thomas, J. A.....Coldwater
Wade, R. L.....Coldwater
Walton, N. J.....Quincy
Weidner, H. R.....M
Woods, R. H.....Quincy

Calhoun County

Amos, Norman H.....M
Baribeau, R. H.....Battle Creek
Barnhart, Samuel E.....Battle Creek
Becker, H. F.....M
Beuker, Herman.....Marshall
Bonifer, Philip P.....M
Braham, Wilbur.....M
Brainard, C. W.....M
Campbell, Alice.....Albion
Campbell, R. J.....M
Capron, Manley J.....M
Church, Starr K.....(E).....Marshall
Chynoweth, W. R.....M
Cooper, J. E.....Battle Creek
Curlless, Grant R.....M
Curry, Robert K.....M
Dickson, A. R.....Battle Creek
Dodge, Warren M., Jr.....Battle Creek
Fairbanks, Stephen.....Albion
Finch, D. L.....Battle Creek
Forsyth, J. F.....M
Frank, David L.....M
Fraser, R. H.....Battle Creek
Funk, L. D.....Athens
Gething, Joseph W.....Battle Creek
Giddings, A. M.....Battle Creek
Gilfillan, Margery J.....Battle Creek
Gorsline, Clarence S.....Battle Creek
Graubner, F. L.....M
Hafford, Alpheus T.....Albion
Hansen, E. L.....Battle Creek
Hansen, Harvey C.....M
Harris, R. H.....Battle Creek
Haughey, Wilfrid.....Battle Creek
Heald, C. W.....Battle Creek
Henderson, Louis M.....Albion

Henderson, P. M.....Albion
Herzer, Henry A.....Albion
Hills, Carlson R.....Battle Creek
Holes, Jesse J.....(R).....Mt. Dora, Fla.
Holton, B. G.....Battle Creek
Howard, W. L.....Battle Creek
Hoyt, Aura A.....Battle Creek
Hubly, James W.....M
Humphrey, Archie E.....Marshall
Humphrey, Arthur A.....M
Jeffrey, J. R.....Battle Creek
Jespersion, Lydia.....Battle Creek
Jones, T. K.....M
Keagle, Leland R.....M
Keeler, K. B.....Albion
Kellogg, Carrie S.....Battle Creek
Kingsley, Paul C.....M
Kinde, M. R.....M
Kolvoord, Theodore.....Battle Creek
LaFrance, N. Francis.....Battle Creek
LaPorte, L. A.....Battle Creek
Levy, Joseph.....M
Lewis, W. B.....Battle Creek
Lowe, H. M.....Battle Creek
Lowe, Kenneth.....M
Lowe, Stanley T.....M
MacGregor, Archibald E.....Battle Creek
Manni, Lawrence C.....Battle Creek
McNair, Lawrence.....Albion
Meister, F. O.....M
Melges, F. J.....Battle Creek
Mercer, C. M.....Battle Creek
Morrison, Donald B.....M
Moshier, Bertha.....(R).....Battle Creek
Mullenmeister, H. F.....M
Mustard, Russell.....Battle Creek

Norman, Estelle G.....Battle Creek
Norton, Richard C.....M
Patterson, Adonis.....M
Radabaugh, Clara V.....Battle Creek
Robbert, John.....Battle Creek
Robins, Hugh.....Battle Creek
Rorick, Wilma Weeks.....Battle Creek
Rosenfeld, Joseph E.....Battle Creek
Roth, Paul.....(R).....Battle Creek
Royer, C. W.....M
Schelm, George W.....Battle Creek
Selmon, Bertha L.....Battle Creek
Sharp, A. D.....Albion
Shipp, Leland P.....Battle Creek
Sibilsky, A. Clark.....Battle Creek
Simpson, Robert S.....M
Slagle, Geo. W.....M
Sleight, James D.....M
Smith, T. C.....M
Stadle, Wendell H.....M
Stiefel, Richard.....Battle Creek
Tannenholz, Harold S.....Battle Creek
Taylor, Clifford B.....M
Toms, Roland E.....M
Upson, W. O.....Battle Creek
Van Camp, Elijah.....Battle Creek
Vander Voort, Wm. V.....Hastings
Verity, Lloyd E.....Battle Creek
Vollmer, Maud J.....Moline, Ill.
Walters, F. R.....Battle Creek
Watson, Bernard.....M
Wencke, Carl G.....Battle Creek
Winslow, Rollin C.....Battle Creek
Winslow, Sherwood B.....Battle Creek
Zindler, George A.....Battle Creek
Zinn, Carl.....M

Cass County

Adams, U. M.....Marcellus
Clary, R. I.....M
Cunningham, E. M.....Cassopolis
Hickman, John.....Dowagiatic

Kelsey, James H.....Cassopolis
Loupee, George.....Dowagiatic
Loupee, S. L.....Dowagiatic
Lyman, W. R.....Dowagiatic

Newsome, Otis.....Cassopolis
Pierce, Kenneth C.....Dowagiatic
Rice, Franklin.....M
Zwergel, E. H.....Cassopolis

Chippewa-Mackinac Counties

Birch, William.....M
Blair, H. M.....M
Carr, E. S.....Pickford
Conrad, Geo. A.....Sault Ste. Marie
Cornell, Eliphalet A.....
(H).....Sault Ste. Marie
Cowan, Donald.....Sault Ste. Marie

Gilfillan, E. O.....M
Hagele, Marie A.....Sault Ste. Marie
Hakala, L. J.....M
Harrington, H. M.....Sault Ste. Marie
McBryde, Lyman M.....Sault Ste. Marie
McDonald, Allan W.....Macinac Island
Mertaugh, W. F.....M

Moloney, F. J.....Sault Ste. Marie
Montgomery, B. T.....Sault Ste. Marie
Scott, Dwight.....Sault Ste. Marie
Vegors, Stanley H.....Sault Ste. Marie
Wallen, Le Roy J.....M
Willison, C.....Sault Ste. Marie
Yale, I. V.....Sault Ste. Marie

Clinton County

Cook, Bruno.....Westphalia
Elliott, Bruce R.....Ovid
Foo, Charles T.....St. Johns
Frace, Guy H.....St. Johns

Hart, Dean W.....M
Henthorn, A. C.....St. Johns
Ho, Thomas Y.....St. Johns
Luton, F. E.....St. Johns

McWilliams, W. B.....Maple Rapids
Russell, Sherwood R.....M
Stoller, R. Paul.....M
Wahl, George Edward.....M

Delta-Schoolcraft Counties

Bernier, A. Barrso.....Nahma
Benson, G. W.....Escanaba
Boyce, D. H.....Escanaba
Brenner, Ervin J.....M
Carlton, A. J.....Escanaba
Chenoweth, Nancy R.....(E).....Escanaba
Clausen, Claire H.....M
Defnet, Harry John.....Escanaba

Diamond, J. A.....Gladstone
Frenn, N. J.....Bark River
Fyvie, James.....M
Gross, Harold Quinten.....Escanaba
Groos, Louis P.....Escanaba
Hult, Otto S.....Gladstone
Kitchen, A. S.....Escanaba
Lemire, Wm. A.....M

Lindquist, N. L.....Manistique
Lockwood, C. E.....Manistique
McInerney, Edna C.....Escanaba
McInerney, Thomas A.....M
Miller, Albert H.....Gladstone
Moll, G. W.....Escanaba
Shaw, George A.....Manistique
Walch, J. J.....Escanaba

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Dickinson-Iron Counties

Addison, E. R.....Crystal Falls
Alexander, W. H.....Iron Mountain
Boyce, George R.....Iron Mountain
Browning, James L.....Iron Mountain
Cooper, C. A.....Stambaugh
De Salvo, F.....Niagara, Wisc.

Fiedling, Wm.....Norway
Frederickson, Geron.....Iron Mountain
Gloss, Kenneth E.....M
Haight, Harry H.....M
Hayes, R. E.....Sagola
Huron, W. H.....Iron Mountain

Irvine, L. E.....Iron River
Kofmehl, Wm. J.....Stambaugh
McEachran, Hugh.....M
Menzie, Clifford.....Iron Mountain
Neuwirth, A. A.....Stambaugh
Retallack, R. C.....M
Smith, Donald R.....Iron Mountain

Eaton County

Arner, Fred Levi.....Bellevue
Brown, B. Philip.....M
Burdick, Austin F.....Grand Ledge
Carothers, Daniel J.....M
Clements, F. W.....Eaton Rapids
Engle, Paul.....Olivet
Goff, S. B.....M

Hannah, H. W.....Charlotte
Hargrave, Don V.....Eaton Rapids
Huber, Chas. D.....Charlotte
Huyck, Stanhope Pier.....M
Imthun, Edgar F.....M
McLaughlin, C. L. D.....Vermontville
Myers, Albert W.....Pottersville
Paine, E. Madison, Jr.....M

Quick, Phil H.....Olivet
Rummell, Robert J.....Grand Ledge
Sassaman, F. W.....Charlotte
Sevener, Lester G.....Charlotte
Stucky, Geo.....Charlotte
Van Ark, Bert.....M
Van Kolken, P. J.....Eaton Rapids

Genesee County

Adams, Chester.....M
Andrews, N. A. C.....M
Anthony, Geo. E.....M
Backus, Glenn R.....M
Baird, James.....Flint
Bald, Frederick W.....M
Barbour, Fleming A.....M
Baske, Franklin W.....Flint
Bateman, L. G.....M
Benson, J. C.....Flint
Bernstein, Eli N.....M
Biggar, H. R.....Flint
Bishop, D. L.....Flint
Blakeley, A. C.....Flint
Bogart, Leon M.....Flint
Boles, William P.....Flint
Bonathan, Alvin T.....Flint
Bradley, Robert.....M
Brain, R. Gordon.....Flint
Branch, Hira E.....M
Brasie, Donald R.....Flint
Briggs, Guy D.....M
Bruce, Wm. W.....M
Buchanan, W. Fremont.....Fenton
Burkett, L. V.....Flint
Burnell, Max.....Flint
Burnside, Howard B.....M
Caster, E. Wilbur.....Flint
Chaffee, Elsa.....Flint
Chambers, Myrton S.....Flint
Chandler, M. E.....Flint
Charters, John H.....Flint
Clark, Clifford P.....Flint
Colwell, C. W.....M
Connell, J. T.....Flint
Conover, G. V.....M
Conover, T. S.....Flint
Cook, Henry.....Flint
Covert, F. L.....Gaines
Crane, Harley C.....Flint
Credille, B. A.....Flint
Curry, George.....Flint
Curtin, J. H.....Flint
David, T. George.....Flint
Del Zingro, N.....Davison
Denholm, Nan H.....Flint
Dimond, E. G.....Flint
Dodds, F. E.....Flint
Drewyer, Glen.....M
Edgerton, A. C.....Clio
Eichhorn, Ernest.....Flint
Eickhorst, Thomas N.....M
Ettinger, Ralph D.....Clio
Evers, J. W.....Flint
Farhat, M. M.....M
Finkelstein, T.....M
Flynn, S. T.....M
Foley, S. I.....Flint
Fuller, H. T.....M
Gelenger, Stephen M.....M

Gleason, N. Arthur.....Flint
Goering, George R.....Flint
Golden, H. Maxwell.....Flint
Goodfellow, B. T.....Flint
Gorne, S. S.....M
Gray, Edwin F.....M
Grover, H. F.....Flint
Guile, Earl E.....Flint
Guile, G. S.....Flint
Gundry, G. L.....Grand Blanc
Gutow, J. J.....M
Hague, R. F.....M
Halligan, Raymond S.....Flint
Hamaday, Ruth.....Flint
Handy, John W.....(E).....Flint
Harper, A. W.....Flint
Harper, Homer.....Flint
Harrison, Leo D.....Flint
Hawkins, James E.....Flint
Hays, George A.....M
Hiscock, H. H.....M
Houston, James.....Swartz Creek
Hubbard, Wm. B.....Flint
Huffman, Wilfred L.....Flint
Johnson, Arthur H.....Flint
Johnson, Frank D.....M
Jones, Lafon.....Flint
Kaleta, Edward.....M
Kaufman, Lewis D.....M
Kirk, A. Dale.....Flint
Knapp, M. S.....(R).....Fenton
Kretschmar, A. H.....Flint
Kurtz, J. J.....Flint
Lambert, L. A.....M
Leach, J. L.....Flint
Livesay, Jackson E.....Flint
Logan, G. W.....Flushing
MacDuff, R. B.....Flint
MacGregor, D. M.....Flint
MacGregor, R. W.....Flint
Macksood, Joseph.....Flint
Marsh, H. L.....Flint
Marshall, William H.....Flint
Mason, Elta.....Flint
McArthur, A.....Flint
McArthur, R. H.....M
McGarry, Burton G.....Fenton
Miller, Edwin E.....Flint
Miller, Loren Eugene.....Flint
Miltick, Anthony J.....Flint
Moore, John W.....Flint
Moore, Kenneth B.....Flint
Morrish, Ray S.....Flint
Morrisey, V. H.....Flint
Mosier, Edward C.....Otisville
Odle, Ira.....Flint
Olson, James A.....Flint
O'Neil, C. H.....(R).....Deckerville
Orr, J. Walter.....Flint
Phillips, R. L.....Flint

Pfeifer, A. C.....Mt. Morris
Pratz, O. C.....Flint
Preston, Otto.....Flint
Probert, C. C.....Flint
Randall, H. E.....Flint
Reeder, Frank E.....Flint
Reichard, Orill.....Flint
Reid, Wells C.....Goodrich
Richeson, V.....Flint
Rieth, George F.....M
Reynolds, A. J.....Flint
Roberts, Floyd A.....Flint
Rowley, James A.....Flint
Rundles, Walter Z.....M
Ryneanson, W. J.....Fenton
Sandy, K. R.....M
Scavarda, Charles J.....M
Schiff, B. A.....M
Scott, R. D.....Flint
Shantz, L. O.....Flint
Sleeman, Blythe R.....Linden
Sheeran, Daniel H.....Flint
Shipman, Charles W.....Flint
Smith, D. C.....Flint
Smith, E. C.....Flint
Smith, Maurice J.....M
Sniderman, Benjamin.....Flint
Snyder, Charles E.....M
Sorkin, Morris L.....M
Sorkin, S. S.....M
Stephenson, Robert A.....Flint
Steinman, F. H.....M
Stevenson, W. W.....Flint
Streat, R. W.....Flint
Stroup, C. K.....Flint
Sutherland, James K.....Flint
Sutton, Geo.....Flint
Sutton, M. R.....Flint
Thompson, Alvin.....Flint
Thomson, J. Oscar.....Grand Blanc
Tofeland, Elmer H.....M
Treat, D. L.....Flint
Trumble, G. W.....Flint
Vander Slice, David.....Flint
Van Gorder, Geo.....M
Vary, Edwin P.....M
Walcott, C. G.....M
Ward, Nell.....Flint
Ware, Frank A.....Flint
Wark, D. R.....Flint
Werness, Inga W.....Flint
White, Carl H.....M
White, Herbert.....Flint
Williams, W. S.....Flint
Wiloughby, G. L.....M
Wiloughby, L. L.....Flint
Wills, T. N.....Flint
Woughter, Harold W.....M
Wright, D. R.....Flint
Wyman, J. S.....Flint

Gogebic County

Albert, S. G.....Ironwood
Anderson, Chas. E.....Bessemer
Eisele, D. C.....Ironwood
Gertz, M. A.....Ironwood
Gorrilla, A. C.....Ironwood
Gullickson, Miles.....M

Hendrickson, A. O.....Ironwood
Lieberthal, M. J.....Ironwood
Lieberthal, Paul.....Ironwood
Maccani, Wm. L.....Ironwood
Nezowski, H. T.....Ironwood
O'Brien, A. J.....Ironwood

Pierpont, D. C.....Ironwood
Pinkerton, H. A.....M
Stevens, Chas. E.....Ironwood
Tressel, H. A.....Wakefield
Urquhart, C. C.....Ironwood
Wacek, W. H.....Ironwood

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Grand Traverse-Leelanau-Benzie Counties

Atkinson, C. F.....Traverse City
Baumann, Milton C.....M
Berghorst, John.....Traverse City
Bolan, Ellis J.....Suttons Bay
Brownson, Jay J.....Kingsley
Brownson, Kneale M.....M
Bushong, B. B.....Traverse City
Covey, E. L.....Honor
Ellis, Claude I.....Suttons Bay
Gallagher, W. H.....Traverse City
Gauntlett, J. W.....Traverse City
Goodrich, Dwight.....Traverse City
Grawn, F. A.....Traverse City
Hamilton, Earl E.....M
Huene, Nevin.....M

Huston, Russell R.....Elk Rapids
Hyslop, Wm. T.....Traverse City
Jerome, Jerome T.....Traverse City
Kitson, V. H.....Elk Rapids
Knapp, Jos. L.....M
Kyselka, H. B.....Traverse City
Lemen, Chas. E.....M
Lentz, R. J.....M
Lossman, R. T.....Traverse City
Murphy, Fred E.....Traverse City
★Nickels, M. M.....M
Osterlin, Mark.....Traverse City
Peak, I. F.....Traverse City
Sheets, R. Philip.....Traverse City
Sladek, E. F.....Traverse City

Stone, Fordyce H.....Beulah
Swanton, L.....Traverse City
Swartz, F. G.....Traverse City
Thacker, Fred R.....Frankfort
Thirby, E. L.....Traverse City
Thompson, T. W.....Traverse City
Trautman, Frederick B.....M
Van Leuven, B. H.....Lansing
Way, Lewis R.....M
Weitz, Harry.....Traverse City
Wilcox, Paul H.....Traverse City
Willard, Wm. G.....Benzonia
Willoughby, Frances Lois.....M
Zielke, I. H.....M
Zimmerman, J. G.....Traverse City

Gratiot-Isabella-Clare Counties

Aldrich, Alfred L.....Ithaca
Barstow, D. K.....M
Barstow, Wm. E.....St. Louis
Baskerville, C. M.....Mt. Pleasant
Becker, Myron G.....Edmore
Budge, M. J.....Ithaca
Burch, L. J.....Mt. Pleasant
Burt, C. E.....Ithaca
Carney, T. J.....Alma
Dale, Edward C.....M
Davis, L. L.....M
Drake, Wilkie M.....Breckenridge
DuBois, C. F.....Alma

Graham, B. J.....M
Hall, B. C.....Pompeii
Hammerburg, Kuno.....M
Harrigan, Wm. L.....Mt. Pleasant
Hersee, Wm. E.....M
Hobbs, A. D.....St. Louis
Hyslop, Leland F.....Mt. Pleasant
Johnson, P. R.....Mt. Pleasant
Kilborn, H. F.....Ithaca
Lamb, E. T.....Alma
McArthur, Stewart C.....Clare
Miller, S. W.....M

Oldham, E. S.....M
Putzig, Louis M.....Blanchard
Rondot, E. F.....Lake
Rottschafer, J. L.....M
Silvert, P. P.....Vestaburg
Slattery, F. G.....M
Strange, Russell H.....Mt. Pleasant
Waggoner, R. L.....St. Louis
Wilcox, R. A.....Alma
Wilson, Earl C.....Harrison
Wolfe, Kenneth P.....M
Wood, Cornelius B.....M

Hillsdale County

Alleger, W. E.....Pittsford
Bower, Chas. T.....Hillsdale
Clobridge, C. E.....Allen
Davis, L. A.....Montgomery
Day, Luther W.....Jonesville
Douglas, E. W.....Hillsdale
Fisk, Fred B.....Jonesville
Green, B. F.....Hillsdale

Hamilton, A. J.....Hillsdale
Hanke, Geo. R.....Ransom
Hodge, C. L.....Reading
Hughes, Henry F.....Hillsdale
Johnson, C. E.....M
Kinzel, R. W.....M
Kline, Fred D.....Litchfield
MacNeal, John A.....Hillsdale
Martindale, E. A.....Hillsdale

Mattson, H. F.....M
McFarland, O. G.....North Adams
Miller, Harry C.....Hillsdale
Moench, George F.....Hillsdale
Sandor, A. A.....M
Sawyer, Walter W.....M
Sterling, John S.....Jerome
Strom, A. W.....M

Houghton-Baraga-Keweenaw Counties

Abrams, James C.....Calumet
Acocks, J. R.....M
Aldrich, A. B.....Houghton
Aldrich, Addison D.....Houghton
Aldrich, Leonard.....M
Bourland, Phillip D.....Calumet
Brewington, George F....(E).....Mohawk
Burke, John.....Hubbell
Coffin, Leslie E.....Painesdale
Gregg, W. T. S.....(E).....Calumet
Hillmer, R. E.....Beacon Hill
Janis, A. J.....Hancock
Kadin, Maurice.....M

King, Wm. T.....Ahmeek
Kirtan, Joseph R. W.....Calumet
Kolb, F. E.....M
LaBine, Alfred.....Houghton
Levin, Simon.....Houghton
MacQueen, Donald K....(E).....Laurium
Manthei, W. A.....Lake Linden
Marshall, Frank F.....L'Anse
McClure, Robert James.....Calumet
Murphy, Percy C.....Ahmeek
Pleune, R. E.....M
Quick, James B.....Laurium

Roche, A. C.....Calumet
Roche, Andrew M.....Calumet
Sarvela, H. L.....Hancock
Sloan, P. S.....Houghton
Smith, Charles R.....Houghton
Stahr, H. S.....Newberry
Stern, Isadore D.....Houghton
Tinetti, Ernest F.....M
Ware, H. M.....Nalma
Whitmore, R. C.....Hancock
Wickliffe, T. P.....Calumet
Willson, P. H.....Chassell
Winkler, Henry J.....L'Anse

Huron County

Gettle, Roy R.....Kinde
Henderson, J. Bates.....Sebewaing
Herrington, Charles I.....Bad Axe
Herrington, Willet J.....Bad Axe

Holdship, Wm. B.....Uby
Monroe, Duncan J.....Elkton
Morden, Charles B.....Bad Axe

Oakes, C. W.....Harbor Beach
Ritsema, John.....Sebewaing
Scheirer, C.....Pigeon
Thumme, Harrison F.....Sebewaing

Ingham County

Atkinson, Everett H.....E. Lansing
Badgley, W. O.....Lansing
Barrett, C. D.....Mason
Bartholomew, Henry S.....
(R).....Harbor Beach
Bauer, Theodore I.....Lansing
Behen, Wm. C.....Lansing
Bellinger, E. G.....Lansing
Black, Charles E.....Williamston
Black, Gertrude.....Williamston
Bobczynski, Wilhelmina E.....Lansing
Bradford, C. W.....Lansing
Breakey, Robert S.....Lansing
Briede, Paul.....Lansing
Brubaker, Earl.....Lansing

Brucker, Karl B.....Lansing
Bruegel, Oscar H.....E. Lansing
Burhans, Robert.....M
Cameron, W. J.....Lansing
Carr, E. I.....Lansing
Christian, L. G.....Lansing
Clark, William E.....M
Clinton, George R.....M
Cook, R. J.....Lansing
Cope, H. E.....Lansing
Corneliuson, Goldie B.....Lansing
Corsaut, J. C.....Mason
Cross, Frank S.....Lansing
Cummings, G. D.....Lansing
Darling, L. H.....Lansing

Dart, Dorothy.....Lansing
Dean, Carleton.....Lansing
DeKleine, William.....Lansing
DeLay, C. P.....Webberville
DeVries, C. F.....Lansing
Doyle, Charles R.....M
Doyle, C. P.....Lansing
Drolett, Donald J.....M
Drolett, Fred J.....Lansing
Drolett, Lawrence.....M
Dunn, F. M.....Lansing
Ellis, Bertha W.....Lansing
Ellis, C. W.....Lansing
Feeney, Kenneth J.....Lansing
Finch, Russell L.....Lansing

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Fisher, D. W. M
 Fosget, Wilbur W. Lansing
 Foust, E. H. Lansing
 French, Horace L. Lansing
 Galbraith, Dugald A. Lansing
 Gardner, C. B. Lansing
 Gibson, T. E. M
 Goldner, R. E. M
 Gunderson, George Lansing
 Heald, Gordon H. M
 Harris, Herbert W. M
 Harrold, J. F. M
 Hart, L. C. Lansing
 Haze, Harry A. Lansing
 Haynes, H. B. Lansing
 Heckert, Frank B. Lansing
 Heckert, J. K. Lansing
 Hendren, Owen M
 Henry, L. L. Lansing
 Himmelberger, R. J. M
 Hodges, Kenneth P. M
 Holland, Charles F. E. Lansing
 Huggett, Clare C. M
 Hughes, Howard Allen M
 Huntley, Fred M. Lansing
 Hurth, M. S. Lansing
 Johnson, H. K. M
 Jones, Francis A. Lansing
 Jones, Francis, Jr. Lansing
 Kalmbach, R. E. Lansing
 Keim, C. D. Lansing
 Kelly, William H. M
 Kent, Edith Hall. Lansing
 Kent, Herbert K. Lansing
 Larrabee, E. E. Williamston
 LeDuc, Don M. M

Ley, Wilfred M
 Loree, Maurice C. Lansing
 Lucas, T. A. Lansing
 Ludlum, L. C. Lansing
 Markuson, Kenneth E. Lansing
 Martin, Wayne O. Lansing
 McConnell, E. G. (R)
 Elizabeth City, N. C.
 McCorvie, C. Ray. E. Lansing
 McCoy, Earl M. Grand Ledge
 McCrumb, R. R. Lansing
 McElmurry, Leland R. Lansing
 McGillicuddy, Oliver B. M
 McGillicuddy, R. J. M
 McIntyre, J. Earl. Lansing
 McNamara, William E. Lansing
 Meade, Wm. H. M
 Mercer, Walter E. M
 Meyer, Hugh R. Lansing
 Miller, H. A. Lansing
 Mitchell, A. B. Lansing
 Morrison, C. V. Lansing
 Morrow, R. J. M
 Myers, V. C. Lansing
 O'Sullivan, Gertrude Mason
 Pinkham, R. A. Lansing
 Ponton, J. Mason
 Prall, H. J. Lansing
 Randall, O. M. Lansing
 Rector, Frank L. Lansing
 Richards, F. D. M
 Richardson, M. L. Lansing
 Roberts, Russell. Lansing
 Robson, Edmund J. M
 Rozan, J. S. Lansing
 Rozan, M. M. M
 Russell, Claude V. (R) Lansing

Sander, John F. M
 Seger, Fred L. Lansing
 Shaw, Milton. Lansing
 Shepherd, Clara S. Lansing
 Sherman, G. A. E. Lansing
 Sichler, Harper G. Lansing
 Silverman, Irving E. M
 Smith, A. V. Mason
 Smith, H. M. Lansing
 Smith, Lillian R. Lansing
 Snell, D. M. Lansing
 Snyder, LeMoyne. Lansing
 Stanka, Andrew G. Grand Ledge
 Spencer, Perry. M
 Steiner, A. A. Lansing
 Stiles, Frank. M
 Strauss, P. C. Lansing
 Swartz, Frederick. M
 Tamblyn, F. W. M
 Thiehoff, E. V. Lansing
 Thomas, L. G. M
 Toothaker, Kenneth. M
 Town, F. R. Lansing
 Towne, Lawrence C. Lansing
 Troost, F. L. Holt
 Vander Sice, E. R. Lansing
 Vander Zalm, T. P. M
 Venier, J. H. Lansing
 Wadley, R. Lansing
 Webb, Roy O. Lansing
 Welch, William H. Lansing
 Wellman, John M. M
 Wetzel, John O. Lansing
 Wilensky, Thomas. Lansing
 Wiley, Harold W. Lansing
 Willson, Howard S. Lansing
 Wilson, Harry A. Lansing

Ionia-Montcalm Counties

Benison, Arthur L. M
 Bird, Wm. L. Greenville
 Botting, A. J. Portland
 Bracey, L. E. Sheridan
 Bunce, E. P. Trufant
 Bunce, Leo. M
 Cook, George Harvey. Ionia
 Dunkin, Lloyd S. M
 Fleming, J. C. Pewamo
 Fox, Harold M. Portland
 Geib, O. P. Carson City
 Hansen, Carl M. M
 Hansen, M. M. Greenville
 Haskell, Robert H. Northville

Hay, John R. Saranac
 Hoffs, M. A. Lake Odessa
 Hollard, A. E. Belding
 Imus, H. L. Ionia
 Johns, Joseph J. Ionia
 Kelsey, L. E. Lakeview
 Kling, V. F. M
 Lilly, Isaac S. Stanton
 Marsh, F. M. Ionia
 Marston, L. L. M
 McCann, John J. Ionia
 Mintz, Morris J. M
 Murawa, V. J. Ionia

Norris, Wm. W. Portland
 Peabody, C. H. Lake Odessa
 Pankhurst, C. T. Ionia
 Robertson, P. C. Ionia
 Seidel, Karl E. M
 Slagh, Milton E. M
 Socha, Edmund S. Ionia
 Swift, E. R. Lakeview
 VanDuzen, V. L. Grand Rapids
 VanLoo, J. A. M
 Weaver, Harry B. Greenville
 Whitten, R. R. Ionia
 Willits, C. O. Saranac

Jackson County

Ahronheim, J. H. M
 Alter, R. H. Jackson
 Anderson, W. B. Jackson
 Appel, S. M
 Baker, G. M. Parma
 Balconi, Henry. Jackson
 Bartholic, F. W. M
 Beckwith, S. A. Stockbridge
 Bullen, G. R. Jackson
 Chabut, H. M. Jackson
 Chivers, R. W. Jackson
 Clarke, C. S. Jackson
 Cochrane, Wayne A. Jackson
 Cooley, Randall M. Jackson
 Corley, C. Jackson
 Corley, Ennis H. Jackson
 Cox, Ferdinand. Jackson
 Crowley, Edward D. M
 Culver, Guy D. Stockbridge
 DeMay, C. E. Jackson
 Dengler, C. R. Jackson
 Edmonds, J. M. M
 Enders, W. H. Jackson
 Filip, H. K. Jackson
 Finton, Walter L. Jackson
 Finton, W. R. M
 Foust, W. L. Grass Lake
 Gibson, F. J. Jackson
 Glover, H. G. (R) Jackson
 Gordon, D. L. M
 Greenbaum, Harry. M
 Habenicht, Hilda. Jackson
 Hackett, T. E. Jackson
 Hanft, Cyril F. Springport

Hanna, R. J. M
 Hardie, G. C. Jackson
 Harris, Lester J. Jackson
 Hicks, Glenn C. Jackson
 Holst, John B. M
 Huntley, W. B. Jackson
 Hurley, H. L. Jackson
 Kiefer, A. H. Concord
 Kudner, Don F. Jackson
 Lake, Wm. H. Jackson
 Lathrop, William W. (E) Jackson
 La Victoire, Isaac N. M
 Leahy, E. O. Jackson
 Lenz, C. R. M
 Leonard, Clyde A. Jackson
 Lewis, E. F. Jackson
 Lojaco, Salvatore. Jackson
 Ludwick, J. E. M
 McGarvey, W. E. Jackson
 McLaughlin, M. J. Jackson
 McLaughlin, Herbert B. M
 Meads, J. B. Jackson
 Miller, J. L. M
 Munro, C. D. Jackson
 Munro, James E. Jackson
 Murphy, B. M. M
 Newton, R. E. Jackson
 Oleksy, S. M
 O'Meara, James J. Jackson
 Otis, Grant L. M
 Payne, Andrew K. Jackson
 Phillips, G. Jackson
 Pier, C. T. Jackson
 Porter, H. W. Jackson

Pray, Frank F. Jackson
 Pray, George R. Jackson
 Ransom, F. G. Jackson
 Riley, Philip A. Jackson
 Roberts, Arthur J. (E) Jackson
 Schepeler, C. W. Brooklyn
 Schmidt, T. E. Jackson
 Scott, John A. M
 Seybold, Edward G. M
 Shaeffer, A. M. Jackson
 Sill, Henry W. Jackson
 Sirhal, Alfred M. M
 Smith, Dean W. Jackson
 Speck, John W. Jackson
 Southwick, W. A. M
 Stewart, L. L. Jackson
 Sugar, Samuel. M
 Susskind, M. V. M
 Tate, Cecil E. M
 Thayer, E. A. Jackson
 Thalner, L. F. Jackson
 Torwick, E. T. Jackson
 Townsend, J. W. Vandercook Lake
 Van Schoick, J. D. Hanover
 Van Schoick, Frank. Jackson
 Van Wagnen, F. I. M
 Vivirski, Edward E. M
 Wertenberger, M. D. Jackson
 Wholihan, John W. Michigan Center
 Wickham, W. A. M
 Wilson, N. D. Jackson
 Winter, G. E. Jackson
 Woodward, George D.
 Sault Ste. Marie

Kalamazoo County

Aach, Hugo. M
 Adams, DeWitt. Newberry
 Anderson, K. A. Kalamazoo
 Alexander, C. A. Kalamazoo

Andrews, Sherman. M
 Armstrong, Robert J. Kalamazoo
 Banner, Lawrence R. Kalamazoo
 Barnebee, J. W. Kalamazoo

Behan, Gerald W. Galesburg
 Benjamin, Margaret. Kalamazoo
 Bennett, Charles L. Kalamazoo
 Bennett, Keith. M

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Berry, J. F.....Kalamazoo
Bodmer, H. C.....Kalamazoo
Borgman, Wallace.....M
Boys, C. E.....Kalamazoo
Brown, I. W.....Kalamazoo
Caldwell, Geo. H.....Kalamazoo
Cobb, Horace R.....Kalamazoo
Cook, R. G.....Kalamazoo
Crane, W. B.....Kalamazoo
Crawford, Kenneth.....M
Dahlstrom, Doris.....Kalamazoo
DenBleyker, Walter.....Kalamazoo
DeWitt, L. H.....Kalamazoo
Dowd, B. J.....M
Doyle, F. M.....M
Ertell, Wm. Francis.....Kalamazoo
Fast, R. B.....Kalamazoo
Fopeano, John V.....M
Fulkerson, C. B.....Kalamazoo
Fuller, R. T.....Kalamazoo
Fuller, Paul.....M
Gerstner, Louis.....Kalamazoo
Gilding, Joseph.....M
Goodhue, Lolita.....Kalamazoo
Grant, Frederick E.....Kalamazoo
Green, William.....Kalamazoo
Gregg, Sherman.....Kalamazoo
Heersma, H. S.....Kalamazoo
Hildreth, R. C.....Kalamazoo
Hobbs, Edw. J.....Galesburg
Hodgman, Albert B.....M
Hoebeke, William G.....Kalamazoo
Holder, Charles.....M
Howard, W. H.....Galesburg

Hubbell, R. J.....Kalamazoo
Huyser, William C.....Kalamazoo
Irwin, William D.....M
Jackson, Howard C.....M
Jackson, John B.....Kalamazoo
Jennings, W. O.....Kalamazoo
Kavanaugh, Wm. R.....M
Kenzie, W. N.....(No address)
Klerk, W. J.....M
Koestner, Paul.....M
Kuks, Milton L.....M
Lambert, R. H.....Kalamazoo
Lang, W. W.....Kalamazoo
Lavender, Howard.....Kalamazoo
Light, Richard Upjohn.....Kalamazoo
Light, S. Rudolph.....Kalamazoo
Littig, John.....Kalamazoo
MacGregor, J. R.....M
Malone, James G.....M
Margolis, Frederick J.....Kalamazoo
Marshall, Don.....M
Marshall, Evelyn W.....Kalamazoo
McCarthy, J. S.....Kalamazoo
McIntyre, Charles H.....M
Moe, Carl Rex.....M
Morter, Roy A.....Kalamazoo
Nell, Edward R.....M
Nibbelink, Benjamin.....Kalamazoo
Okun, M. H.....M
Patmos, Martin.....M
Peelen, Matthew.....M
Perry, Clifton.....Kalamazoo
Pratt, F. A.....Kalamazoo
Prentice, Hazel R.....Kalamazoo

Rigterink, G. H.....M
Rigterink, H. A.....Kalamazoo
Rockwell, Donald C.....Kalamazoo
Ryan, F. C.....M
Sage, E. D.....Kalamazoo
Scholten, D. J.....Kalamazoo
Scholten, Wm.....Kalamazoo
Schrier, C. M.....M
Schrier, Paul.....M
Schrier, Thomas.....M
Scott, Wm. A.....M
Shackleton, Wm. E.....Kalamazoo
Shook, R. W.....M
Siemson, W. J.....M
Simpson, B. W.....Kalamazoo
Simson, Clyde B.....M
Snyder, Roscoe F.....Kalamazoo
Sofen, Morris B.....M
Stiller, Anthony F.....Kalamazoo
Southworth, M. N.....M
Stryker, Homer H.....Kalamazoo
Upjohn, E. Gifford.....Kalamazoo
Upjohn, L. N.....Kalamazoo
Van Urk, Thomas.....Kalamazoo
Verhage, Martin D.....M
Volderauer, John C.....M
Wagar, Carl.....Kalamazoo
Wagenaar, E. H.....M
Walker, Burt D.....Kalamazoo
Westcott, L. E.....Kalamazoo
Wilbur, E. P.....Kalamazoo
Youngs, A. S.....Kalamazoo
Youngs, C. A.....Kalamazoo
Zolen, Margaret.....Kalamazoo

Kent County

Adams, F. A.....M
Aitken, George T.....M
Alexander, Marshall O.....Grand Rapids
Alfenito, Felix S.....M
Allen, R. V.....Grand Rapids
Avery, Noyes L.....Vancouver, Wash.
Bachman, G. A.....Grand Rapids
Baert, Geo. H.....Grand Rapids
Baker, Abel J.....Grand Rapids
Ballard, M. S.....Grand Rapids
Balyeat, Gordon W.....M
Beaton, James H.....M
Beeman, Carl B.....M
Beeman, C. E.....Grand Rapids
Beets, W. Clarence.....M
Bell, Charles M.....M
Bergsma, Stuart.....Grand Rapids
Bettison, Wm. L.....M
Billings, Elton P.....Grand Rapids
Blackburn, Henry M.....Grand Rapids
Blossom, Paul W.....Grand Rapids
Boelkins, Richard C.....M
Boet, F. A.....Grand Rapids
Boet, John.....M
Bond, Geo. Lewis.....Grand Rapids
Bosch, L. C.....Grand Rapids
Brace, Fred.....M
Brayman, C. W.....Cedar Springs
Brink, Russell.....M
Brook, Jacob D.....Grandville
Browning, Eugene S.....Grand Rapids
Brotherhood, J. S.....Grand Rapids
Buesing, O. R.....M
Buist, S. J.....Grand Rapids
Bull, Frank L.....Sparta
Burleson, John S.....Grand Rapids
Burling, Wesley M.....Grand Rapids
Burnett, Paul C.....Grand Rapids
Burroughs, Frank.....M
Butler, Wm. J.....Grand Rapids
Byers, Earl J.....Grand Rapids
Byrd, Mary Lou.....Grand Rapids
Campbell, Alexander M.....Grand Rapids
Carpenter, Luther Clarendon.....M
Chadwick, W. L.....M
Chamberlain, L. H.....Grand Rapids
Chandler, Donald.....Grand Rapids
Claytor, R. W.....Grand Rapids
Collisi, Harrison S.....M
Colvin, W. G.....M
Corbus, Burton R.....Grand Rapids
Cosgrove, Wm. J.....M
Crane, Charles V.....Grand Rapids
Crane, Harold D.....M
Cuncannan, M. E.....Grand Rapids
Currier, F. P.....Grand Rapids
Dales, Ernest W.....Grand Rapids
Damstra, H. J.....M
Davis, D. B.....M
Dean, Alfred W.....Grand Rapids
DeBoer, Clarence J.....M
DeBoer, Guy Wm.....M

DeMaagd, Gerald.....Rockford
DeMol, Richard J.....Grand Rapids
Denham, R. H.....Grand Rapids
Denham, Robert H., Jr.....M
DePree, Isla G.....Grand Rapids
DePree, Joseph.....Grand Rapids
DeVel, Leon.....M
DeVries, Daniel.....M
DeWar, M. D.....Grand Rapids
Dewey, Kent A.....Grand Rapids
Dick, Mark W.....M
Dickstein, Bernard.....M
Diskey, Donald.....Grand Rapids
Dixon, Willis L.....Grand Rapids
Doran, Frank L.....Grand Rapids
Droste, James C.....Grand Rapids
DuBois, Wm. J.....Grand Rapids
Duiker, Henry.....Grand Rapids
Eaton, Robert M.....M
Eggleston, H. R.....Grand Rapids
Elliott, James A.....Grand Rapids
Failing, John F.....M
Fannaff, Frank L.....Grand Rapids
Farber, Charles E.....M
Faust, L. W.....Grand Rapids
Fee, Manson G.....M
Fellows, Kenneth E.....M
Ferguson, James.....M
Ferguson, Lynn A.....Grand Rapids
Ferguson, Ward S.....Grand Rapids
Ferrand, L.....M
Fitts, Ralph L.....M
Flynn, J. D.....M
Foshee, J. C.....Grand Rapids
Frantz, C. H.....M
Freyling, Robert.....M
Fuller, E. H.....Grand Rapids
Gaikema, E. W.....Grand Rapids
Gibbs, F. F.....Grand Rapids
Gilbert, R. H.....Grand Rapids
Grant, Lee O.....Grand Rapids
Griffith, L. S.....M
Haack, William.....M
Hagerman, D. B.....Grand Rapids
Hammond, T. W. (R.).....Grand Rapids
Hardy, Faith F.....Grand Rapids
Hayes, L. W.....Howard City
Heetderks, Dewey.....Grand Rapids
Henry, James, Jr.....Grand Rapids
Herrick, Ruth.....Grand Rapids
Hill, A. Morgan.....M
Hilt, Lawrence M.....M
Hodgen, J. T.....Grand Rapids
Holcomb, J. W.....Grand Rapids
Holdsworth, M. J.....M
Holkeboer, Henry D.....Grand Rapids
Hollander, Stephen.....M
Hoogerhyde, Jack.....M
Houghton, G. D.....Caledonia
Hufford, A. R.....Grand Rapids
Hunderman, Edward.....Grand Rapids
Hutchinson, Robert J.....Grand Rapids

Hyland, W. A.....Grand Rapids
Ingersoll, C. F.....M
Jameson, Fred M.....M
Jaracz, W. J.....Grand Rapids
Jarvis, Charles.....Grand Rapids
Kelly, Robert E.....M
Kemmer, Thomas R.....Grand Rapids
Kendall, Eugene L.....Grand Rapids
Klaus, C. D.....M
Kniskern, P. W.....M
Kooistra, Henry P.....Grand Rapids
Koontz, Henry R.....M
Kremer, John.....Grand Rapids
Kreulen, H. J.....Grand Rapids
Kriekard, P. J.....Grand Rapids
Krupp, C. G.....Grand Rapids
Laird, Robert G.....Grand Rapids
Lamb, George F.....Grand Rapids
Lannign, N. E.....Grand Rapids
Lawrence, Howard C.....Grand Rapids
Lentini, Joseph R.....M
Le Roy, Simeon.....Grand Rapids
Liefiers, Harry.....Grand Rapids
Logie, James W.....Grand Rapids
Lyman, William D.....Grand Rapids
MacDonell, James A.....M
Marrin, M. M.....M
Marsh, John P.....Grand Rapids
Maurits, Reuben.....Grand Rapids
McCandless, Robert.....Grand Rapids
McCormick, John.....M
McDougall, Wm. J.....Grand Rapids
McDougall, Clarice.....Grand Rapids
McKenna, J. L.....M
McKinlay, L. M.....Grand Rapids
McRae, John H.....Grand Rapids
Mehney, Gayle H.....Grand Rapids
Miller, J. Duane.....M
Miller, John J.....Marne
Mitchell, H. C.....M
Mitchell, W. B.....Grand Rapids
Moen, Cornetta G.....Grand Rapids
Moleski, Leo.....M
Moleski, Sanley L.....Grand Rapids
Moll, Arthur M.....Grand Rapids
Mouw, Dirk.....M
Mulder, J. D.....Grand Rapids
Murphy, M. J.....M
Nelson, A. R.....M
Noordewier, Albert.....Grand Rapids
Northouse, Peter B.....Grandville
Oliver, W. W.....Grand Rapids
Patterson, P. Wilfred.....Grand Rapids
Payne, C. Allen.....M
Pedden, J. R., Jr.....Grand Rapids
Posthuma, Millard.....M
Pott, A. L.....M
Pyle, Henry J.....Grand Rapids
Ragsdale, L. V.....Grand Rapids
Ralph, L. Paul.....M
Reed, Torrance.....Grand Rapids
Reus, Wm. F.....Grand Rapids

ROSTER 1945

Rigterink, J. W.....Grand Rapids
 Riley, G. L.....Grand Rapids
 Robb, Charles S.....Grand Rapids
 Roberts, Mortimer E.....Grand Rapids
 Robinson, Harold C.....Grand Rapids
 Rodgers, William L.....Grand Rapids
 Roth, Emil M.....M
 Schermerhorn, L. J.....Grand Rapids
 Schuitema, Donald.....M
 Schnoor, E. W.....Grand Rapids
 Schnute, Louise F.....Grand Rapids
 Sculley, Ray E.....M
 Sevensma, Elisha S.....Grand Rapids
 Sevey, L. E.....Grand Rapids
 Shepard, B. H.....Lowell
 Shellman, Millard W.....M
 Slemmons, C. C.....Grand Rapids
 Sluyter, J. S.....M
 Smith, A. B.....Grand Rapids
 Smith, Edwin M.....Grand Rapids
 Smith, Ferris N.....Grand Rapids
 Smith, R. Earle.....Grand Rapids
 Snyder, Clarence.....Grand Rapids
 Southwick, G. Howard.....Grand Rapids
 Steffensen, W. H.....M

Stonehouse, G. G.....Grand Rapids
 Stover, Virgil E.....M
 Sugg, Cullen E.....Grand Rapids
 Sus Strong, Carl A.....Grand Rapids
 Swenson, H. C.....M
 Swenson, Leland L.....M
 Ten Have, J.....Grand Rapids
 Tesseine, A. J.....M
 Teusink, J. H.....Cedar Springs
 Thompson, Archibald B. (E).....Grand Rapids
 Thompson, P. L.....Grand Rapids
 Tidey, Marcus B.....Grand Rapids
 Tiffany, Jos. G.....Grand Rapids
 Torgerson, Wm. R.....Grand Rapids
 Truog, C. P.....Grand Rapids
 Van Belois, Harvard J.....Grand Rapids
 Van Bree, R. S.....Grand Rapids
 Vanden Berg, Henry J.....Grand Rapids
 Vander Meer, Ray.....M
 VanDuine, H. J.....Byron Center
 Vann, N. S.....Grand Rapids
 Van Noord, Gelmer A.....Grand Rapids
 Van Solkema, Andrew.....Grand Rapids

Van Solkema, Arthur.....M
 Van Woerkom, Daniel.....Grand Rapids
 Van Zwaluwenberg, Benjamin.....M
 Veldman, Harold E.....Grand Rapids
 Venema, J. R.....Grand Rapids
 Ver Meulen, John.....Wyoming Park
 Vis, William R.....Grand Rapids
 Vyn, J. D.....Grand Rapids
 Warnshuis, Frederick C.....(L) Windsor, Ont.
 Webb, Rowland.....Grand Rapids
 Webber, Jerome.....M
 Wedgwood, L. G.....Grandville
 Wells, Merrill.....Grand Rapids
 Wenger, A. V.....Grand Rapids
 Wenger, John W.....Coopersville
 Whalen, John.....M
 Whinery, Joseph B.....Grand Rapids
 Wiggers, J. R.....Grand Rapids
 Willits, P. W.....Grand Rapids
 Wilson, Wm. E.....(R) Grand Rapids
 Winter, Garrett, E.....Grand Rapids
 Woodburne, A. R.....M
 Wright, Thomas B.....Grand Rapids
 Yegge, J. P.....Kent City

Lapeer County

Best, Herbert M.....Lapeer
 Bishop, G. C.....Almont
 Burley, David H.....(E) Almont
 Chapin, Clarence C.....Columbiaville
 Cooper, E. R.....Lapeer
 Dorland, Clarke.....M

Jackson, Carl C.....M
 McBride, J. R.....M
 McLeod, K. W. A.....Lapeer
 Merz, Henry G.....(E) Lapeer
 O'Brien, Daniel J.....Lapeer

Rehn, Adolph T.....Lapeer
 Smith, G. L.....Imlay City
 Thomas, J. Orville.....North Branch
 Tinker, F. A.....(E) Lapeer
 Zemmer, H. B.....Lapeer

Lenawee County

Abraham, A. O.....Hudson
 Blair, Thomas H.....Adrian
 Blanchard, L. E.....Hudson
 Bland, J. P.....Hudson
 Blanden, Merwin R.....Tecumseh
 Campbell, C. A.....M
 Clafin, G. M.....Adrian
 Colbath, W. E.....Adrian
 Claxton, W. T.....M
 Hall, George C.....M
 Hamby, S. B.....Byron
 Hammel, H. H.....M
 Hardy, P. B.....Tecumseh

Heffron, Howard H.....Adrian
 Helzerman, Ralph F.....M
 Hewes, A. B.....Adrian
 Hornsby, W. B.....Clinton
 Howland, F. A.....Adrian
 Iler, Harris D.....M
 Jewett, Wm. E., Jr.....Adrian
 Lamley, Arthur E.....Blissfield
 Loveland, Horace H.....Tecumseh
 MacKenzie, W. S.....Adrian
 McCue, Francis, J., Jr.....M
 McCue, F. J., Sr.....Hudson
 Marsh, R. G. B.....M

Miller, Perry Lynford.....M
 Morden, Esli T.....Adrian
 Pasternacki, Arthur S.....M
 Patmos, Bernard.....M
 Peters, W. L.....Morenci
 Raabe, E. C.....Morenci
 Rawson, A. P.....M
 Rogers, J. D.....M
 Spalding, I. L.....Hudson
 Stafford, Leo J.....Adrian
 Tubbs, R. V.....Blissfield
 Van Dusen, C. A.....Blissfield
 Wynn, G. H.....M

Livingston County

Brigham, Jeanette.....Howell
 Cameron, Duncan A.....M
 Coughlin, Florence J.....Howell
 Crandell, Claire H.....Howell
 Duffy, Ray M.....Pinckney
 Finch, E. D.....Howell

Glenn, Bernard H.....Fowlerville
 Hayner, R. A.....M
 Hendren, J. J.....Fowlerville
 Hill, Harold C.....M
 Huntington, H. G.....Howell
 Laboe, Edward W.....Howell

Leslie, G. L.....M
 McGregor, Archie J.....Brighton
 McDowell, Guy Marshall.....Howell
 Rednor, Daniel J.....Howell
 Sigler, Hollis L.....Howell
 Stephens, D. C.....M

Luce County

Campbell, Earl H.....Newberry
 Gibson, Robert E.....Newberry
 Lance, Paul E.....M

Perry, H. E.....Newberry
 Purmort, William R., Jr.....Newberry

Spinks, Robert Earl.....Newberry
 Surrell, Matthew A.....M
 Swanson, George F.....M

Macomb County

Bauting, O. F.....M
 Barker, J. G.....Centerline
 Berry, Henry G.....(E) Mt. Clemens
 Bower, A. B.....Armada
 Brady, Milo J.....St. Clair Shores
 Crawford, A. M.....Romeo
 Croman, Joseph M., Jr.....Mt. Clemens
 Croman, Joseph M., Sr.....(E) Mt. Clemens
 Deurloo, H. W.....M
 Dudzinski, E. J.....M
 Engels, J. A.....Richmond
 Isbey, Edward K.....Centerline

Kane, Wm. J.....Mt. Clemens
 Lane, M. D.....Romeo
 Lynch, Russell E.....Centerline
 Maguire, A. J.....M
 Moore, C. F.....Mt. Clemens
 Parker, B. Morgan.....Utica
 Reichman, Joseph J.....Mt. Clemens
 Reitzel, Rufus H.....Mt. Clemens
 Rivard, Charles L.....M
 Roth, G. E.....M
 Ruedisueli, Clarence A.....Roseville
 Rothman, A. M.....M
 Salot, R. F.....M

Scher, Joseph N.....M
 Siegfried, E. G.....New Haven
 Smith, Milton C.....Mt. Clemens
 Stone, Elizabeth A.....M
 Sturm, Fred A.....St. Clair Shores
 Thompson, A. A.....Mt. Clemens
 Ullrich, R. W.....Mt. Clemens
 Wellard, Henry C.....M
 Whitley, Alec.....St. Clair Shores
 Wilde, M. M.....Warren
 Wiley, D. Bruce.....Utica
 Wiley, Herbert H.....Utica
 Wolfson, Victor H.....Mt. Clemens

Manistee County

Grant, C. L.....Manistee
 Hansen, E. C.....Manistee
 Konopa, John F.....M
 Lewis, Lee A.....Manistee

MacMullen, Harlen.....Manistee
 Miller E. B.....Manistee
 Norconk, Ward H.....Bear Lake

Oakes, Ellery A.....Manistee
 Ogilvie, G. D.....M
 Quinn, Henry M.....Copemish
 Ramsdell, Homer A.....Manistee

ROSTER 1945

Marquette-Alger Counties

Bennett, Arthur K.....Marquette
 Berry, Robert F.....Marquette
 Bertucci, J. P.....Ishpeming
 Burke, R. A.....Negaunee
 Bottum, Charles N.....Marquette
 Casler, W. L.....Marquette
 Cooperstock, M.....Marquette
 Corcoran, W. A.....Ishpeming
 Drury, Chas. P.....Marquette
 Elzinga, E. R.....Marquette
 Erickson, Arvid W.....Ishpeming
 Fenning, F. A.....M

Hanelin, H. A.....M
 Hartt, P. P.....Ishpeming
 Hirwas, C. L.....Marquette
 Hornbogen, D. P.....M
 Howe, L. W.....Marquette
 Janes, R. Grant.....M
 Keskey, George I.....Marquette
 Lambert, W. C.....M
 LeGolván, C.....Marquette
 McCann, Neal J.....Ishpeming
 Mudge, W. A.....Negaunee
 Narotzky, Archie S.....Ishpeming

Nicholson, J. B.....M
 Niemi, O. I.....M
 Robbins, Nelson J.....Negaunee
 Schutz, W. J.....M
 Schweinsberg, Sara D.....Marquette
 Sicotte, Isaiah.....Michigamme
 Treshler, H. J.....Gwinn
 Talso, Jacob.....Ishpeming
 Vandeventer, Vivian H.....Ishpeming
 Van Riper, Paul.....Champion
 Waldie, George McLeod.....Ishpeming
 Wickstrom, Geo.....Munising

Mason County

Benjamin, Clayton C.....Ludington
 Blanchette, Victor J.....Scottville
 Comodo, Nicholas M.....M
 Goulet, L. J.....Ludington

Hoffman, H. E.....M
 Hoffman, Howard.....M
 Hunt, Ivan L.....Scottville

Lintner, Roy C.....Ludington
 Martin, Wm. S.....Ludington
 Ostrander, R. A.....M
 Paukstis, Charles.....Ludington

Mecosta-Osceola-Lake Counties

Bruggema, Jacob.....Evart
 Chess, Leo F.....Reed City
 Franklin, Benjamin L.....Remus
 Ivkovich, Paul.....M

Kilmer, Paul B.....Reed City
 Klein, J. Paul.....M
 MacIntyre, Donald.....Big Rapids
 Merlo, F. A.....Big Rapids

Phillips, R. W.....M
 Treynor, Thomas P.....Big Rapids
 White, J. A.....Morley
 Yeo, Gordon H.....Big Rapids

Medical Society of North Central Counties

Beeby, R. J.....West Branch
 Clippert, C. G.....Grayling
 Coulter, Keith D.....Gladwin
 Drescher, Geo. A.....Lewiston
 Egle, Joseph L.....Gaylord

Harris, Levi A.....(E) Gaylord
 Hendricks, Henning V.....Kalkaska
 Jardine, Hugh M.....West Branch
 Keyport, C. R.....Grayling
 Lanting, Roelof.....M

McDowell, Douglas B.....M
 McKillop, G. L.....Gaylord
 Peckham, Richard.....Gaylord
 Sargent, Leland E.....M
 Stealy, Stanley.....Grayling

Menominee County

DeWane, F. J.....Menominee
 Flanagan, Clarence B.....Menominee
 Heidenreich, John R.....Daggett
 Jones, Wm. S.....Menominee

Kaye, J. T.....Menominee
 Kerwell, K. C.....Stephenson
 Mason, Stephen C.....Menominee
 Peterson, A. R.....Daggett

Sawbridge, Edward... (E) Stephenson
 Sethney, Henry T.....Menominee
 Sethney, Walter F.....Menominee
 Towey, J. W.....Powers

Midland County

Ballmer, Robert S.....Midland
 Gay, Harold Howard.....Midland
 Grewe, N. C.....Midland
 Hautau, Emily.....Midland
 High, C. V., Jr.....Midland
 Howe, Irvin M.....Midland

Linsenmann, Karl W.....Midland
 MacCallum, Charles.....Midland
 Maynard, W. A.....Coleman
 Meisel, Edward H.....M
 Nicholas, Mildred.....Midland
 Pike, Melvin H.....Midland

Rice, Robert E.....Midland
 Sher, J. H.....Midland
 Sjolander, Gust.....Midland
 Towsley, W. D.....Midland
 Von Haitinger, Kalmon S.....M

Monroe County

Acker, Wm. F.....Monroe
 Ames, Florence.....Monroe
 Balk, A. C.....Monroe
 Barker, Vincent L.....M
 Blakey, L. C.....Monroe
 Bond, W. W.....M
 Cohen, H. Herbert.....M
 Denman, D. C.....M
 Dusseau, S. V.....(E) Erie
 Ewing, R. T.....Monroe
 Fieldhouse, B. J.....Ida
 Flanders, J. P.....M
 Gelhaus, Wm. J.....Monroe

Golinvaux, C. J.....Monroe
 Goodman, Louis.....M
 Heffernan, John F.....Carleton
 Hensel, Hilda.....Monroe
 Heustis, Albert E.....Monroe
 Hunter, M. A.....Monroe
 Johnson, A. Esther.....Monroe
 Landon, Herbert W.....Monroe
 Long, Edgar C.....M
 Long, Sara.....Monroe
 McDonald, T. A.....Monroe
 McGeoch, R. W.....Monroe
 McMillin, J. H.....Monroe

Meck, H. L.....Dundee
 Parmerlee, O. E.....Lambertville
 Penzotti, Stanley.....M
 Pinkus, Hermann.....Monroe
 Reisig, A. H.....M
 Sanger, Emerson J.....Monroe
 Siffer, J. J.....Monroe
 Stolpestad, C. T.....M
 Tomlinson, Ledyard.....Newport
 Vaughn, Morley S.....Carleton
 Wagar, Spencer.....Rockwood
 Williams, Robert J.....M
 Williamson, G. W.....Dundee

Muskegon County

Anderson, A. J.....Muskegon
 Anderson, Axel W.....Lakewood Club
 August, R. V.....Muskegon
 Bartlett, F. H.....Muskegon
 Barnard, Helen.....Muskegon
 Bate, L. C.....Muskegon
 Beers, Charles.....Muskegon Heights
 Benedict, A. L.....M
 Bloom, C. J.....Muskegon
 Boyd, D. R.....Muskegon
 Bradshaw, Park S.....Muskegon
 Chapin, Wm. S.....Muskegon Heights
 Closz, H. F.....Muskegon
 Cohan, Sol G.....Muskegon
 Collier, G. C.....Whitehall

Dasler, A. F.....M
 Derezenski, Clement F.....Muskegon
 Diskin, Frank.....M
 Douglas, Robert.....M
 Ducey, Edward F.....Muskegon
 Durham, C. J.....Muskegon
 Dykhuisen, Harold D.....Muskegon
 Eckerman, C. E.....Muskegon
 Fillingham, Enid.....Muskegon
 Fleischman, C. B.....Muskegon
 Fleischman, Norman.....M
 Foss, Ed O.....Muskegon
 Garber, F. W., Jr.....Muskegon
 Garland, J. O.....Muskegon
 Gillard, James.....M

Goltz, Martha.....Montague
 Griffith, Robert M.....Muskegon
 Hagen, William A.....Muskegon
 Hannum, F. W.....Muskegon
 Harrington, A. F.....Muskegon
 Harrington, R. J.....Muskegon
 Hartwell, S. W.....M
 Heneveld, John.....Muskegon
 Holly, Leland E.....Muskegon
 Holmes, Roy Herbert.....M
 Kane, Thomas J.....M
 Kay, Cecilia.....Muskegon
 Keilin, Marie.....Muskegon
 Kerr, H. J.....M
 Kniskern, E. L.....Muskegon

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LaCore, O. M.....Muskegon Heights
 Lange, E. W.....Muskegon
 Lauretti, Emil.....Muskegon
 Laurin, V. Samuel.....Muskegon
 LeFevre, Louis.....M
 LeFevre, Wm. M.....Muskegon
 Loder, Leonel Lewis.....Muskegon
 Loomis, John L.....Muskegon
 Mandeville, C. B.....Muskegon
 Medema, Paul.....Muskegon
 Meengs, M. B.....M

Miller, Philip L.....M
 Morford, F. N.....Muskegon
 Mulligan, A. W.....Muskegon
 Oden, Constantine L.....Muskegon
 Petkus, Antonie.....Muskegon
 Pettis, Emmett.....Muskegon
 Powers, Lunette.....Muskegon
 Price, Leonard.....M
 Pyle, H. J.....Muskegon
 Risk, R. A.....Muskegon
 Risk, Robert D.....M
 Schollen, W.....M

Ryan, Wm. J. J.....Muskegon
 Sears, Richard.....Muskegon
 Stone, Maxwell E.....Muskegon
 Struthers, J. N. P.....Muskegon
 Swartout, W. C.....Muskegon
 Teifer, Charles A.....Muskegon
 Thieme, S. W.....Ravenna
 Thornton, E. S.....Muskegon
 Wiersma, Silas C.....Muskegon
 Wilke, C. A.....Montague
 Wilson, P. S.....Muskegon

Newaygo County

Deur, T. R.....Grant
 Geerlings, Lambert.....Fremont
 Geerlings, Willis.....Fremont

Gordon, B. F.....M
 Moore, H. R.....Newaygo

O'Neill, J. W.....White Cloud
 Stryker, O. D.....Fremont
 Tompsett, Arthur C.....Hesperia

Northern Michigan

Benson, A. A.....Mancelona
 Beuker, Bernard.....East Jordan
 Blum, Benjamin B.....M
 Burns, Dean C.....Petoskey
 Conkle, Guy C.....Boyne City
 Conti, Joseph.....M
 Conway, Wm. S.....M
 Duffie, Don Hastings.....Central Lake
 Frank, Gilbert E.....Harbor Springs
 Gervers, J. H. R.....Bellaire

Giffords, Mark.....M
 Hegener, A. J.....Petoskey
 Larson, Walter E.....Cheboygan
 Lashmet, Floyd H.....Petoskey
 Lilga, Harris V.....M
 Litzenburger, A. F.....Boyne City
 Mast, W. H.....Petoskey
 Mayne, Frederick C.....Cheboygan
 McCarrroll, James C.....Santa Clara, Cal.
 McCune, Wm. Stanley.....M
 McLeod, M. M.....Petoskey

McMillan, Fraley.....Charlevoix
 McMillan, Lyle D.....Mackinaw City
 Miller, Samuel L.....Jackson
 Palmer, Russell.....St. James
 Parks, W. H.....Petoskey
 Rodgers, John.....Bellaire
 Saltonstall, Gilbert B.....Charlevoix
 Stringham, J. R.....Cheboygan
 Van Dellen, Jerrian.....East Jordan
 Wood, George H.....Onaway

Oakland County

Abbott, V. C.....M
 Arnkoff, Harry.....Pontiac
 AschenBrenner, Z. R.....Farmington
 Baker, Frederick A.....Pontiac
 Baker, Robert H.....Pontiac
 Barker, Howard B.....Pontiac
 Bauer, Ernest W.....Hazel Park
 Beattie, W. G.....Ferndale
 Beck, Otto O.....Birmingham
 Benning, C. H.....M
 Berg, Richard H.....Oxford
 Blue, Jane.....Elizabeth Lake
 Borland, Alexander.....Pontiac
 Boucher, R. E.....M
 Burke, Chauncey G.....Pontiac
 Butler, Samuel A.....Pontiac
 Calhoun, Ethel T.....Birmingham
 Campbell, Malcolm D.....M
 Carr, Wm. H.....Holly
 Christie, Edward D.....Pontiac
 Christie, J. W.....M
 Church, J. E.....Pontiac
 Cobb, Leon F.....Pontiac
 Cobb, Thomas H.....Pontiac
 Cooper, Robert J.....M
 Cottrell, Martha S.....Novi
 Crissman, Harold C.....Ferndale
 Cudney, Ethan B.....Pontiac
 Dahlgren, Carl.....Keego Harbor
 Darling, C. G., Jr.....Pontiac
 Dobski, Edwin J.....M
 Dunstone, H. C.....Pontiac
 Ekeland, Clifford T.....Pontiac
 Farnham, Lucius A.....Pontiac
 Faulconer, Albert A.....M
 Ferris, Ralph G.....Birmingham
 Fitzpatrick, Francis.....Pontiac
 Flick, Earl J.....M
 Flick, John R.....Royal Oak
 Foust, Earl W.....M
 Fox, John W.....Pontiac
 Francis, Donald.....M
 Furlong, Harold.....M
 Gaensbauer, Ferdinand.....Pontiac
 Garipey, Bernard F.....Royal Oak
 Gatley, C. R.....M
 Geib, L. Warren.....Pontiac
 Gayle, Ormond D.....Rochester
 Gehringer, Norman F.....M
 Gerls, Frank B.....Pontiac
 German, Frank D.....Pontiac

Gibson, Wellington C.....Milford
 Grant, William A.....Milford
 Grate, L.....M
 Green, Wm. M.....Pontiac
 Hackett, Daniel Jos.....Pontiac
 Haddock, D. A.....Walled Lake
 Halsted, Lee H.....Farmington
 Hammer, Carl W.....M
 Hammonds, E. E.....M
 Harvey, Campbell.....Pontiac
 Hasner, R. B.....Royal Oak
 Hassberger, J. B.....M
 Hathaway, Clarence L.....Lake Orion
 Hathaway, William.....Rochester
 Henry, Colonel R.....Ferndale
 Hensley, C. B.....Lake Orion
 Howlett, E. V.....Pontiac
 Hoyt, D. F.....M
 Hubert, John R.....M
 Huffman, M. R.....Milford
 Hume, T. W. K.....Auburn Heights
 Hurst, Daniel D.....Pleasant Ridge
 Hutchinson, W. G.....Bloomfield Hills
 Jones, Morrell M.....Drayton Plains
 Kemp, Felix J.....Pontiac
 Kemp, W. Lloyd.....Birmingham
 Kimball, A. S.....Pontiac
 Kirkup, Norman N.....Hazel Park
 Koehler, William H.....Royal Oak
 Lambie, John S.....Birmingham
 Lambert, Alvin Gerald.....Ferndale
 Larson, B. T.....Pontiac
 Lass, E. H.....M
 Lewis, S. M.....Ferndale
 Little, J. W.....M
 MacKenzie, O. R.....Walled Lake
 Margrave, Edmund C.....Royal Oak
 Markley, John Martin.....M
 Mason, Robert J.....M
 McConkie, J. P.....Birmingham
 McEvoy, Francis J.....M
 McNeill, H. H.....Pontiac
 Mehas, C. P.....Pontiac
 Meinke, Herman A.....Hazel Park
 Mercer, Frank A.....Pontiac
 Merrill, Lionel N.....Royal Oak
 Mitchell, B. M.....Pontiac
 Monroe, John D.....Pontiac
 Montgomery, Marian Z.....Pontiac
 Neafie, Chas. A.....Pontiac

Needle, Francis.....M
 Newcomb, Arnold B.....Berkley
 Norup, John.....Berkley
 Nosanchuk, Joseph.....M
 Ohlmacher, A. P.....M
 Olsen, Richard E.....M
 Pauli, Theodore H.....Pontiac
 Pool, H. H.....Pontiac
 Porritt, Ross J.....M
 Ports, Preston W.....M
 Prevette, Isaac C.....Pontiac
 Raynale, George P.....Birmingham
 Reid, Fred T.....Clawson
 Riker, Aaron D.....Pontiac
 Roehm, Harold R.....Birmingham
 Ross, Worth.....Bloomfield Hills
 Rowley, Laurie G.....Drayton Plains
 Russell, Vincent P.....M
 St. John, Harold A.....Pontiac
 Schlechte, Carl.....M
 Schlechte, Eve Marian.....Rochester
 Schoenfeld, John B.....M
 Schuneman, Howard.....Ferndale
 Seaborn, A. J.....Royal Oak
 Shadley, Maxwell.....M
 Sheffield, L. C.....Pontiac
 Sibley, H. A.....Pontiac
 Simpson, E. K.....Pontiac
 Smith, Carleton A.....M
 Smith, Donald S.....M
 Smith, Ellen.....Pontiac
 Spears, M. L.....Pontiac
 Spencer, Lloyd H.....M
 Spoehr, Eugene L.....Ferndale
 Spohn, Earl W.....M
 Stahl, Harold F.....Oxford
 Stanley, Wm. F.....M
 Starker, Clarence T.....Pontiac
 Steinberg, Norman.....Royal Oak
 Stolpman, A. K.....M
 Sutton, Palmer.....Royal Oak
 Swickle, Edward F.....Royal Oak
 Tuck, Raymond G.....Pontiac
 Uloth, Milton J.....Ortonville
 Vatz, Jack A.....Pontiac
 Wagley, P. V.....Pontiac
 Wagner, Ruth E.....Royal Oak
 Warner, J. F.....Pontiac
 Wentz, A. E.....M
 Young, Arthur R.....Pontiac

Oceana County

Flint, Charles.....M
 Hayton, A. R.....Shelby
 Heard, Wm.....Pentwater
 Heysett, Norman W.....Pentwater

Jensen, Viggo.....Shelby
 Lemke, Walter M.....M
 Munger, L. P.....Hart

Nicholson, John H.....Hart
 Reetz, Fred A.....Shelby
 Robinson, W. Gordon.....M
 Wood, Merle G.....Hart

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Ontonagon County

Bender, Jesse L.....Mass

Hogue, H. B.....Ewen
Rubinfeld, S. H.....M

Strong, W. F.....Ontonagon

Ottawa County

Beernink, E. H.....Grand Haven
Bloemendaal, D. C.....Zeeland
Bloemendaal, W. B.....Grand Haven
Boone, Cornelius E.....Zeeland
Clark, Nelson H.....M
Cook, Carl S.....M
Costello, Clarence Vincent...Holland
DeYounge, Fred.....Spring Lake..M
DeVries, H. C.....Holland
Hager, R.....M
Hamelink, M. H.....Holland

Harms, H. P.....M
Kemme, Gerrit.....Zeeland
Kitchel, John.....Grand Haven
Kitchel, Mary.....Grand Haven
Kools, William Clarence...Holland
Leenhouts, Abraham.....(E)...Holland
Longe, C. E.....Grand Haven
Nichols, Rudolph H.....Holland
Nykamp, Russell.....Zeeland
Presley, Wm. J.....Grand Haven
Rypkema, Willard M.....M

Stickley, A. E.....Coopersville
Ten Have, Ralph.....Grand Haven
Timmerman, E. C.....M
Van Appledorn, Chester J....Holland
Van Der Berg, E.....Holland
Van der Velde, O.....Holland
Wells, Kenneth.....M
Westrate, William.....Holland
Winter, John K.....Holland
Winter, Wm. G.....M

Saginaw County

Ackerman, G. L.....M
Bagley, U. S.....Saginaw
Bagshaw, David E.....Saginaw
Berberovich, T. F.....Saginaw
Bishop, H. M.....M
Brender, Fred P.....Frankenmuth
Brock, W. H.....Saginaw
Bruton, Martin F.....Saginaw
Busch, Frank J.....Saginaw
Butler, M. G.....M
Button, A. C.....Saginaw
Cady, F. J.....Saginaw
Cameron, Allen K.....Saginaw
Campbell, L. A.....Saginaw
Catizone, R. J.....Merrill
Chisena, Peter R.....M
Claytor, Archer A.....Saginaw
Cortopassi, Andre.....Saginaw
Cortopassi, V. E.....M
Cory, C. W.....M
Curtis, James.....M
Durman, Donald C.....Saginaw
Ely, C. W.....Saginaw
Eymmer, Esther.....Saginaw
Fleschner, Thos. E.....Birch Run
Galsterer, Edwin C.....Saginaw
Gerber, Herbert.....M
Goman, Louis D.....Saginaw
Grigg, Arthur.....(E)...Saginaw
Grigg, Arthur P.....M
Hand, Eugene.....M
Harvie, L. C.....Saginaw
Helmkamp, Herbert O.....Saginaw

Hohn, Fred J., Jr.....Saginaw
Howell, Don M.....Saginaw
Imerman, Harold M.....M
Jaenichen, R.....Saginaw
James, J. W.....M
Jiroch, R. S.....Saginaw
Jordan, Leo A.....Saginaw
Keller, S. S.....Saginaw
Kemp, J. N.....Saginaw
Kempton, R. M.....Saginaw
Kerr, William.....M
Kirchgeorg, Clemens G...Frankenmuth
Kleekamp, H. G.....Saginaw
Knott, Harriet A.....Lapeer
Kowals, F. V.....Saginaw
Ling, Ernest M.....Hemlock
Lohr, O. W.....Saginaw
Longstreet, Martha L.....Saginaw
Luger, F. E.....M
Lurie, Robert.....M
Lyle, R. C.....Bridgeport
MacKinnon, Edward D.....Saginaw
MacMeekin, James Ware.....M
Martzowka, Wm. P.....Saginaw
Maurer, John A.....M
Mayne, Harold.....Saginaw
McKinney, Alex R.....Saginaw
McLandress, Joshua A.....Saginaw
Meyer, Henry J.....Saginaw
Mikan, V. Robert.....Saginaw
Moon, A. R.....Saginaw
Mudd, Richard D.....M
Murphy, Albert P.....Saginaw

Murray, Chas. R.....M
Murray, M. J.....Saginaw
Novy, F. O.....Saginaw
O'Reilly, William J.....(E)...Saginaw
Ostrander, Frank W.....Freeland
Phillips, Homer A.....M
Pietz, Frederick.....Saginaw
Pillsbury, Edward A.....Frankenmuth
Potvin, Clifford D.....M
Poole, Frank A.....Saginaw
Richards, Ned W.....M
Richter, Harry J.....M
Ryan, M. D.....(E)...Saginaw
Ryan, R. S.....M
Sample, J. T.....Saginaw
Sargent, D. V.....M
Schaiberger, Elmer G.....Saginaw
Schneider, Alexander.....M
Sheldon, S. A.....M
Skrowronski, Casimer A.....Saginaw
Slack, Walter K.....M
Stahly, Edward H.....Saginaw
Standar, A. C.....M
Stewart, George W.....M
Thomas, Dale.....Saginaw
Tiedke, G. E.....M
Toshach, C. E.....Saginaw
Treshler, H. J.....Gwinn
Wallace, Herbert C.....M
Westlund, Norman.....Saginaw
Wilson, H. Roy.....Saginaw
Yntema, S.....M

Sanilac County

Blanchard, E. W.....Deckerville
Ellis, N. J.....Croswell
Gift, W. A.....Marlette
Hart, R. K.....Croswell

Koch, D.....M
Learmont, H. H.....Croswell
McGuegle, K. T.....Sandusky
Norgaard, Hal V.....M
Seager, M. Cole.....Brown City

Sebille, Louis Joseph.....M
Tweedie, G. Evans.....Sandusky
Tweedie, S. Martin.....Sandusky
Webster, John C.....Marlette

Shiawassee County

Arnold, Alfred L., Jr.....Owosso
Arnold, A. L., Sr.....(E)...Owosso
Backe, John C.....M
Bennett, George W.....Elsie
Brandell, J. M.....M
Brown, Richard J.....M
Buzzard, Walter D.....M
Fillinger, W. B.....Ovid

Hoshal, Vern L.....Durand
Hume, Arthur M.....(E)...Owosso
Hume, Harold A.....Owosso
Janci, Julius.....M
Lenden, V. E.....M
Merz, W. L.....Chesaning
McKnight, E. R.....M
Parker, W. T.....Owosso
Pochert, R. C.....Owosso

Richards, C. J.....Durand
Shepherd, W. F.....Owosso
Slagh, E. M.....Elsie
Soule, Glenn T.....Henderson
Watts, Fred A.....Owosso
Weinkauf, W. F.....Corunna
Weston, C. L.....Owosso
Wilcox, Anna L.....Owosso
Wilcox, C. M.....M

St. Clair County

Armsbury, A. B.....Marine City
Atkinson, J. M.....Port Huron
Attridge, J. A.....Port Huron
Banting, K. C.....M
Battle, J. C. S.....Port Huron
Beck, Frank K.....Port Huron
Biggar, R. J.....M
Borden, C. L.....Port Huron
Boughner, W. H.....Algonac
Bovee, M. E.....Port Huron
Brush, Howard O.....Port Huron
Burke, Ralph M.....Port Huron
Burley, Jacob H.....Port Huron
Callery, A. L.....Port Huron

Carey, Lewis M.....Detroit
Carney, F. V.....St. Clair
Clyne, B. C.....M
Cooper, T. H.....Port Huron
DeGurse, T. E.....Marine City
Derck, W. P.....Port Huron
Edwards, Albert C.....Port Huron
Feldman, Gordon G.....Yale
Fraser, Robert C.....Port Huron
Hall, W. E. B.....Port Huron
Holcomb, R. J.....Marine City
Kesi, Geo. Matthew.....Port Huron
Le Galley, K. B.....M
Licker, R. R.....M

Ludwig, F. E.....M
Martin, C. S.....Port Huron
McColl, D. J.....Port Huron
McColl, Neil J.....Port Huron
MacPherson, C. A.....St. Clair
Meredith, E. W.....Port Huron
Patterson, D. Webster.....Port Huron
Pollock, Donald A.....Yale
Reynolds, Annie E.....Port Huron
Ryerson, W. W.....Port Huron
Schaefer, W. A.....Port Huron
Searles, Karl F.....Capac
Sites, E. C.....Port Huron
Thomas, C. F.....Port Huron

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Treadgold, Douglas.....Port Huron
Vroman, M. E.....Port Huron
Ware, John R.....Port Huron

Wass, Henry C.....St. Clair
Waters, George.....Port Huron
Wellman, Joseph E.....Port Huron

Wight, William G.....Yale
Witter, Gordon L.....M
Zemmer, A. L.....Port Huron

St. Joseph County

Berg, Lawrence A.....M
Blood, J. V.....Three Rivers
Brunson, A. E.....Colon
Corkill, C. C.....White Pigeon
Fiegel, S. A.....M
Fortner, R. J.....Three Rivers
Hoekman, Aben.....M

Holm, Arvid G.....M
Kane, David M.....Sturgis
Miller, C. G.....Sturgis
Parrish, Marion.....Sturgis
Pennington, H. C.....M
Raisch, Fred J.....M
Reed, Fred R.....Three Rivers
Rice, John W.....M

Shaw, G. D.....M
Sheldon, J. P.....M
Slote, L. K.....Constantine
Springer, R. A.....Centerville
Sweetland, G. J.....Constantine
Weir, Dale C.....Three Rivers
Wilkinson, Nina C.....Sturgis
Zimont, R. D.....M

Tuscola County

Barbour, Harry A.....Mayville
Bates, George.....(E) Kingston
Dickerson, Willard W.....Caro
Dixon, Robert L.....Wahjamega

Donahue, H. Theron.....Cass City
Fisher, Robert E.....M
Gugino, Frank James.....M
Hoffman, T. E.....M
Howlett, R. R.....M

Johnson, O. G.....Mayville
Merrill, Elmer H.....Caro
Savage, L. L.....Caro
Vail, Harry F.....M

Van Buren County

Boothby, Carl.....M
Boothby, F. M.....Lawrence
Boothby, Paul R.....M
Bope, William P.....Decatur
Buckborough, M. W.....South Haven
Diephuis, Bert.....M
French, Merle R.....Paw Paw
Gano, Avison.....M
Giddings, Ralph R.....M
Giffen, John R.....Bangor

Greenman, Newton H.....Decatur
Hall, E. J.....M
Hasty, Willis A.....M
Hoyt, W. F.....(E) Paw Paw
Iseman, Joseph W.....M
Itzen, J. F.....South Haven
Laird, Emma.....Paw Paw
Lowe, Edwin G.....Bangor
Maxwell, J. Charles.....Paw Paw
McNabb, A. A.....Kalamazoo

Murphy, Norman B.....Bangor
Penoyar, C. L.....South Haven
Sayre, Phillip P.....Onsted
Spalding, R. W.....Gobles
Steele, Arthur H.....Paw Paw
TenHouten, Chas.....M
Terwilliger, Edwin.....M
Urist, Martin J.....South Haven
Williams, F. N.....Hartford
Young, William R.....Lawton

Washtenaw County

Adock, John D.....Ann Arbor
Agate, George H.....M
Alexander, John.....Ann Arbor
Andros, George J.....Ann Arbor
Armstrong, Richard C.....M
Badgley, Carl E.....Ann Arbor
Baer, Louis S.....M
Baker, David M.....M
Baker, R. Ray.....Ann Arbor
Barker, Paul S.....Ann Arbor
Barnes, Allan C.....M
Barnwell, John B.....Ann Arbor
Barr, Albert S.....Ann Arbor
Barss, H. D.....Ypsilanti
Bass, Thomas J.....Ypsilanti
Bassett, Robert C.....Ann Arbor
Bassow, Paul H.....Ann Arbor
Bauer, Gerhard H.....M
Bauer, Jere M.....Ann Arbor
Baugh, Richard H.....Ann Arbor
Beall, John G.....Ann Arbor
Beebe, Hugh M.....Ann Arbor
Bell, Margaret.....Ann Arbor
Belser, Walter.....Ann Arbor
Bethell, Frank H.....Ann Arbor
Boyer, Philip A.....Ann Arbor
Brace, William M.....Ann Arbor
Breakey, J. F.....(R) Ann Arbor
Britton, H. B.....Ypsilanti
Brown, Philip N.....Ypsilanti
Bruce, James D.....Ann Arbor
Bryant, W. Leroy.....Ann Arbor
Bullington, Bert M.....M
Bulmer, Dan J.....M
Buscaglia, C. J.....M
Buxton, Robert W.....Ann Arbor
Camp, C. D.....Ann Arbor
Clarke, Robert B.....Ann Arbor
Clements, Glenn T.....Ann Arbor
Cody, Claude Carr.....Ann Arbor
Coller, Frederick A.....Ann Arbor
Conger, Karyl B.....M
Conn, Jerome W.....Ann Arbor
Cooper, Ralph R.....M
Coxon, Alfred W.....Ann Arbor
Crabtree, Peter.....M
Cummings, Howard H.....Ann Arbor
Cummings, Robert H.....M
Curtis, Arthur C.....Ann Arbor
Davis, Fenimore E.....M
Day, A. Jackson.....M
deAlvarez-Skinner, Russell R.....M
deJong, Russell N.....Ann Arbor
DeTar, John S.....Milan
Dimitroff, Sim.....M
Dingman, Reed O.....Grand Rapids
Donaldson, S. W.....Ann Arbor

Dowman, Charles E.....M
Duff, Ivan F.....M
Emerson, Herbert W.....Ann Arbor
Engelke, Otto K.....Ann Arbor
Everett, Meldon.....M
Falls, Harold F.....Ann Arbor
Farrior, J. Brown.....M
Fitzgerald, Thomas D.....M
Fletcher, Donald B.....M
Forsythe, Warren E.....Ann Arbor
Foster, D. Bernard.....M
Fralick, F. Bruce.....Ann Arbor
Friedman, Harford W.....Ann Arbor
Frye, Carl H.....Ann Arbor
Furstenberg, A. C.....Ann Arbor
Ganzhorn, Edwin C.....Ann Arbor
Gardiner, Sprague H.....M
Gates, John L.....Ann Arbor
Gates, Neil A.....Ann Arbor
Green, Merwin E.....M
Grekin, John N.....Ann Arbor
Gule, Andros.....Chelsea
Haas, Reynold L.....Ann Arbor
Hagerman, George W.....M
Haight, Cameron.....Ann Arbor
Hammond, George.....M
Hammond, W. W., Jr.....Plymouth
Handorf, Heinrich H.....Northville
Hannum, M. R.....Milan
Harris, B. M.....M
Henry, L. Dell.....Ann Arbor
High, Howard C., Jr.....M
Himler, Leonard E.....Ann Arbor
Hirschfield, Alexander H.....M
Hoagland, Thomas V.....Ypsilanti
Hodges, Fred J.....Ann Arbor
Holt, John F.....Ann Arbor
Howard, S. C.....Ann Arbor
Howes, Homer A.....M
Hunt, Homer H.....M
Jay, Baird D.....M
Jimenez, Buenaventura.....Ann Arbor
Johnson, L. J.....M
Johnston, Sture A. M.....Ann Arbor
Jordan, Paul H.....M
Kahn, Edgar A.....M
Kambly, Arnold H.....M
Keller, Arthur P.....M
Kemper, John W.....Ann Arbor
Kiehn, Clifford L.....M
Kimbrough, Robert C., Jr.....M
Kleinschmidt, Earl E.....M
Kleinschmidt, Gladys J.....Mt. Pleasant
Klingman, Theophil.....Ann Arbor
Klunzinger, Willard R.....Ann Arbor
Knoll, Leo A.....Ann Arbor
LaFever, Sidney L.....Ann Arbor

Lampe, Isadore.....Ann Arbor
Law, John L.....Ann Arbor
Levin, Manuel.....M
Lichty, Dorman E.....Ann Arbor
List, Carl F.....Ann Arbor
Lowell, Vivion F.....M
Lynn, Harold Philip.....Ypsilanti
Lyons, Richard H.....Ann Arbor
McCotter, Rollo E.....Ann Arbor
McEachern, Thomas H.....Ann Arbor
MacIntyre, Dugald S.....M
MacKaye, Lavinia G.....Ann Arbor
Malcolm, Karl D.....Ann Arbor
Marshall, Mark.....Ann Arbor
Martin, Donald W.....Ypsilanti
Maxwell, James H.....Ann Arbor
Milford, Albert F.....Ypsilanti
Miller, Harold A.....M
Miller, Norman F.....Ann Arbor
Moore, Donald F.....M
Morrow, Grant.....Ann Arbor
Muehlig, George F.....Ann Arbor
Myers, Dean W.....Ann Arbor
Nesbit, Reed M.....Ann Arbor
Newton, Charles W.....Ann Arbor
Northway, Robert O.....Ann Arbor
Oliphant, L. W. (Mrs.).....Barton Hills
Palmer, A. A.....M
Parsons, Robert J.....M
Patrick, Gilbert T.....Ann Arbor
Patterson, Ralph M.....Ann Arbor
Pearson, Edwin O.....Ann Arbor
Peet, Max M.....Ann Arbor
Pillsbury, Charles B.....Ypsilanti
Pollard, H. Marvin.....Ann Arbor
Potter, Marcia.....Ypsilanti
Power, Frank H.....M
Price, Helen F.....Ann Arbor
Prout, Gordon J.....Saline
Quirk, Edmund J.....Chelsea
Rague, Paul O.....M
Ransom, Henry K.....Ann Arbor
Raphael, Theophile.....Ann Arbor
Ratliff, Rigdon K.....Barton Hills
Rawling, Frank F. A.....Ann Arbor
Reynolds, Stephen.....M
Riecker, Herman H.....Ann Arbor
Riggs, Harold.....Ann Arbor
Robb, David N.....Ypsilanti
Rosekrans, Sarah D.....Ann Arbor
Rosenbaum, Francis F.....Ann Arbor
Ross, C. Howard.....Barton Hills
Salon, Dayton D.....M
Sauer, William N.....Ann Arbor
Schumacher, W. E.....Ann Arbor
Scott, Robert R.....M
Scott, William C.....M

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Scurry, Maurice.....M
 Seever, Maurice H.....Ann Arbor
 Seime, Reuben I.....Ypsilanti
 Sibbald, Malcolm.....Chelsea
 Sinai, Nathan.....Ann Arbor
 Sink, Emory W.....Ann Arbor
 Smailley, Marianna.....Ann Arbor
 Smith, Eleanor.....Ann Arbor
 Smith, Joseph G.....M
 Snow, Glenadine.....Ypsilanti
 Solis, Jeanne C.....(E) Ann Arbor
 Stoddard, Frederick J.....M
 Sturgis, Cyrus C.....Ann Arbor

Sundwall, John.....Ann Arbor
 Teed, R. Wallace.....M
 Thieme, E. Thurston.....M
 Towsley, Harry A.....M
 Trimby, Robert H.....Ann Arbor
 Valk, William L.....M
 Waggoner, Raymond W.....Ann Arbor
 Waldron, Alexander M.....M
 Wallace, J. B.....(R) Saline
 Wanstrom, Ruth C.....Ann Arbor
 Washburne, C. L.....Ann Arbor
 Watson, Ernest H.....Ann Arbor
 Weller, Carl V.....Ann Arbor

Wellman, Waldron W.....Ypsilanti
 Wessinger, John A.....(E) Ann Arbor
 Wile, Udo J.....M
 Williams, Howard R.....Ann Arbor
 Williamson, F. B.....Ypsilanti
 Wilson, Frank N.....Ann Arbor
 Wilson, James L.....Ann Arbor
 Wisdom, Inez R.....Ann Arbor
 Woods, J. J.....Ypsilanti
 Worth, Melissa H.....Ypsilanti
 Wright, W. J.....Ypsilanti
 Wylie, W. C.....Dexter
 Yoder, O. R.....Ypsilanti

Wayne County

Aaron, Charles D.....(E) Detroit
 Abbott, William E.....Detroit
 Abrams, Harry M.....Detroit
 Abramson, Max.....Detroit
 Abuzzo, Anthony M.....M
 Adams, James Robert.....Dearborn
 Adelson, Sidney L.....M
 Adler, Sidney.....M
 Agins, Jacob.....Detroit
 Agnelly, Edward J.....Detroit
 Agnew, George H.....Detroit
 Albrecht, Herman, F.....Detroit
 Alderman, R. F.....Detroit
 Aldrich, E. Gordon.....Detroit
 Aldrich, Napier.....M
 Allen, John V.....Lincoln Park
 Alles, Russell W.....Detroit
 Allison, Frank B.....Detroit
 Allison, Herbert C. Grosse Pte. Farms
 Altman, Raphael.....Detroit
 Altshuler, Abraham M.....Detroit
 Altshuler, Ira M.....Detroit
 Altshuler, Samuel S.....M
 Amberg, Emil (E).....Detroit
 Amolsch, Arthur Lewis.....Detroit
 Amos, Thomas G.....Detroit
 Anderson, Bruce.....Detroit
 Anderson, Gordon H.....M
 Anderson, J. O.....Detroit
 Anderson, Walter L.....M
 Anderson, Walter T.....Detroit
 Andries, George G.....Detroit
 Andries, J. H.....Detroit
 Andries, Raymond C.....Detroit
 Ankley, J. W.....Detroit
 Annessa, Dommenico Marcilli.....Detroit
 Anslow, Robert E.....Detroit
 Appel, Phillip R.....Detroit
 Appelman, H. B.....Detroit
 Arehart, Burke W.....M
 Arent, John G.....Detroit
 Armstrong, Arthur G.....Detroit
 Arnold, William J.....Detroit
 Arnold, Effie.....Detroit
 Aronstam, Noah E.....Detroit
 Arrington, Robyn J.....Detroit
 Ascher, Meyer S.....M
 Ashe, Stilson R.....Detroit
 Ashley, L. Bryan.....M
 Ashton, F. B.....Highland Park
 Asselin, J. L.....Detroit
 Asselin, Regis F.....M
 Athay, Roland M.....Detroit
 Atchison, Russell M.....Northville
 Atler, Lawrence R.....Detroit
 Atler, Leroy L.....M
 Aubel, M. E.....Detroit
 August, Harry E.....M
 Auld, Douglas V.....Wayne
 Axelrod, Stanley H.....Detroit
 Axelson, A. U.....Detroit
 Babcock, Kenneth B.....M
 Babcock, L. K.....Detroit
 Babcock, Myra E.....Detroit
 Babcock, W. W.....Detroit
 Bacalis, Anastasios.....Detroit
 Bach, Walter F.....Detroit
 Bachman, Morris E.....Detroit
 Bacon, Vinton A.....Detroit
 Baer, George J.....Detroit
 Baer, Raymond B.....Detroit
 Baef, Michael A.....Detroit
 Bagley, Harry E.....M
 Bailey, Carl C.....M
 Bailey, Don A.....Detroit
 Bailey, Louis J.....Detroit
 Baker, Clarence.....Detroit
 Bakst, Joseph.....Detroit
 Balcerski, Matthew A.....Detroit
 Ballard, Charles S.....Detroit
 Balser, Chas. W.....Detroit
 Baltz, James I.....Detroit
 Baranowski, A. W.....Detroit
 Barnes, Donald J.....Detroit
 Barnett, Saul E.....Detroit

Barnett, Louis L.....Detroit
 Barnett, Morton.....Detroit
 Barone, Charles J.....Highland Park
 Barrett, Wyman D.....Detroit
 Barron, William H.....Detroit
 Bartemeier, Leo H.....Detroit
 Barton, J. R.....Detroit
 Bates, Gaylord.....M
 Bates, Morton.....Wayne
 Bauer, Benedict J.....Detroit
 Bauer, A. Robert.....Detroit
 Bauer, Lester Eugene.....M
 Baumann, W. L.....Detroit
 Baumer, Moe.....M
 Baumgarten, Elden C.....Detroit
 Bayles, John G.....Detroit
 Beach, Watson.....Detroit
 Beam, A. Duane.....M
 Beaton, Colin.....M
 Beattie, Robert.....Detroit
 Beaver, Donald C.....Detroit
 Beck, Eva F.....Eloise
 Becker, Abraham.....M
 Becker, Jos. Wm.....Detroit
 Becklein, C. L.....Detroit
 Beckwitt, M. C.....M
 Bedell, A.....Detroit
 Beer, Joseph F.....M
 Beeuwkes, L. E.....M
 Begle, H. L.....Detroit
 Behn, Claud W.....Detroit
 Beigler, Sydney K.....Detroit
 Beitman, Max R.....M
 Belanger, Ernest E.....M
 Belanger, Henry.....Detroit
 Belanger, Wm. George.....M
 Belknap, Warren E.....M
 Bell, J. Kenner.....Detroit
 Bennett, Germany E.....Detroit
 Bennett, Harry B.....Detroit
 Bennett, Sanford A.....Detroit
 Bennett, Zina B.....Detroit
 Benson, C. D.....M
 Benson, Davis.....M
 Benson, Virginia.....Detroit
 Bentley, Frederick E.....Plymouth
 Bentley, Neil I.....Detroit
 Berent, Morris S.....Detroit
 Beresh, Louis.....M
 Berge, Clarence A.....Detroit
 Bergman, Murray Stewart.....Detroit
 Bergo, Howard L.....M
 Berke, Sydney S.....Detroit
 Berkey, Wm. E.....Detroit
 Berlien, Ivan C.....M
 Berman, Lawrence.....Detroit
 Berman, Robert.....Detroit
 Berman, Sidney.....M
 Bernard, Walter G.....Detroit
 Bernbaum, Bernard.....Detroit
 Bernstein, Albert E.....Detroit
 Bernstein, Samuel S.....M
 Besancon, J. H.....M
 Best, T. H. Edward.....Detroit
 Bicknell, Edgar A.....M
 Bicknell, Frank B.....M
 Bicknell, Nathan J.....Detroit
 Birch, John R.....M
 Birkelo, Carl C.....Detroit
 Bittker, I. Irving.....Detroit
 Black, Perry S.....Detroit
 Blain, Alexander, III.....Detroit
 Blain, Alexander W.....Detroit
 Blain, James H., Jr.....M
 Blair, K. E.....Detroit
 Blanchet, Alfred D.....Detroit
 Blashill, James B.....M
 Blau, Morris H.....Detroit
 Bleier, Joseph.....Detroit
 Bloch, Abraham.....Detroit
 Blodgett, William E.....Detroit
 Blodgett, William H.....M
 Bloom, Arthur R.....Detroit
 Bloomer, Earl.....Dearborn
 Blumenthal, Franz L.....Detroit

Boccaccio, John.....M
 Boccia, James J.....M
 Boddie, Lewis Franklin.....Detroit
 Boddie, Arthur W.....Detroit
 Boehm, John D.....Detroit
 Boell, Arthur F.....Detroit
 Bogusz, Ladislaus.....Eloise
 Bohn, Stephen.....M
 Boileau, Thornton I.....M
 Boles, A. E.....M
 Bookmyer, R. H.....Detroit
 Bookstein, Abraham M.....M
 Boutrous, Thomas A.....Detroit
 Bovill, Edwin G.....M
 Bower, Franklin T.....Detroit
 Bowers, Leo J.....Detroit
 Bowman, Frank E.....Detroit
 Boyd, John H.....Trenton
 Brachman, D. S.....Detroit
 Bracken, Andrew H.....Dearborn
 Bradford, Henry.....M
 Bradley, George.....Detroit
 Bradshaw, Wm. H.....Detroit
 Brady, Herbert A.....River Rouge
 Braiman, Louis.....Detroit
 Brancheau, L. T.....M
 Braley, W. N.....Detroit
 Bramick, F. W.....Detroit
 Brand, Benjamin.....Detroit
 Brando, Russell G.....Detroit
 Brandt, Edward L.....Detroit
 Braun, Lionel.....M
 Brekke, Viola G.....Detroit
 Breitenbecher, Edw. R.....Detroit
 Brengle, Deane R.....Detroit
 Breon, Guy L.....Detroit
 Briegel, Walter A.....Detroit
 Brines, O. A.....M
 Bringard, Elmer L.....M
 Brisbois, Harold J.....Plymouth
 Bromme, William.....M
 Brooks, A. L.....Detroit
 Brooks, Clark D.....Detroit
 Brooks, Charles W.....M
 Brooks, Nathan.....M
 Brosius, William L.....Detroit
 Broudo, Philip H.....Detroit
 Brough, Glen A.....M
 Brouwer, Stephen W.....Detroit
 Brown, A. O.....Detroit
 Brown, Carlton F.....M
 Brown, Frances.....Detroit
 Brown, Gordon T.....Detroit
 Brown, Harvey F.....Detroit
 Brown, Henry S.....Detroit
 Brown, John R.....M
 Brown, Samuel M.....Detroit
 Brown, Stanley H.....Detroit
 Brown, Thomas A.....Detroit
 Brownell, Paul G.....M
 Bruehl, Richard.....Detroit
 Brunk, Andrew S.....Detroit
 Brunk, Clifford F.....Detroit
 Brunke, Bruno B.....Detroit
 Brush, Brock Edwin.....Detroit
 Bryce, John D.....M
 Buchanan, W. Paul.....Detroit
 Buchner, Harold W.....M
 Buck, John D.....Detroit
 Budson, Daniel.....Detroit
 Buell, Charles E., Jr.....Detroit
 Buesser, Frederick G.....Detroit
 Buller, H. L.....Detroit
 Burbidge, Earl L.....Detroit
 Burby, John J.....Detroit
 Burgess, Chas. M.....Detroit
 Burgess, Jay M.....Detroit
 Burnham, David C.....Detroit
 Burnstine, Julius Y.....Detroit
 Burnstine, Perry P.....M
 Bundrant, Herschel B.....Detroit
 Burr, George C.....Detroit
 Burr, H. Leonard.....Grosse Pointe
 Burrows, Howard A.....Dearborn

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Burstein, Harry S.	Detroit	Cole, James E.	Detroit	Dorsey, John M.	Detroit
Burstein, I. Marvin	Detroit	Cole, Wyman C. C.	M	Doty, Chester A.	Detroit
Burstein, Morris M.	Detroit	Coleman, Margaret W.	Detroit	Doub, Howard P.	Detroit
Burton, D. T.	Detroit	Coleman, Wm. G.	Redford	Douglas, Bruce H.	Detroit
Bush, Glendon	M	Coll, Howard R.	Detroit	Douglas, Clair L.	M
Bush, Lowell M.	Detroit	Collings, M. Raymond	Detroit	Dovitz, Benjamin W.	Detroit
Buss, John A.	Detroit	Collins, Arthur D.	M	Dow, Roy E.	Detroit
Butler, Harry J.	Detroit	Collins, James D.	Detroit	Dowdle, Edward	Detroit
Butler, L. H.	Detroit	Colvin, Leslie T.	Detroit	Dowling, H. E.	M
Butler, Volney N.	Detroit	Colyer, Raymond G.	Detroit	Downer, Ira G.	Detroit
Butterworth, Herman	Lincoln Park	Comstock, Lawrence	Trenton	Doyle, George H.	Detroit
Buttrum, Edward J.	Detroit	Connelly, Richard C.	Detroit	Drake, Ellet H.	M
Byers, Dudley W.	Detroit	Connolly, Frank	Detroit	Drake, James J.	Detroit
Byington, Garner M.	Detroit	Connolly, John P.	Detroit	Draves, Edward F.	Detroit
Cadieux, Henry W.	Detroit	Conley, L. C. M.	Detroit	Dreus, Robert S.	Detroit
Caldwell, J. Ewart	M	Connors, J. J.	Detroit	Drinkhaus, Harold I.	Detroit
Caldwell, George L.	Detroit	Conrad, E. R.	Detroit	Droock, Victor	Detroit
Callkins, H. N.	M	Constable, Canute G.	Detroit	Dubnov, Aaron	Detroit
Callaghan, T. T.	M	Cooksey, Warren B.	Detroit	DuBois, Paul W.	Detroit
Cameron, A. H.	Wyandotte	Cook, James C.	M	Dubbernell, Karl	Detroit
Campau, George H.	Detroit	Coolidge, M. Belle	Grosse Pt. Park	Dubbernell, Martin S.	Detroit
Campbell, Duncan	Detroit	Cooper, E. L.	Detroit	Dudek, John J.	Wyandotte
Campbell, Duncan A.	Detroit	Cooper, James B.	Detroit	Duffy, Edward A.	Detroit
Campbell, Malcolm D.	Detroit	Corbelle, Catherine	Detroit	Dundas, Edw. M.	Detroit
Campbell, Mary B.	Detroit	Coseglia, Robert P.	Detroit	Dunlap, Henry A.	Detroit
Candler, Clarence L.	Detroit	Costello, Russell T.	Detroit	Dunlap, Samson F.	Detroit
Canter, Allie L.	Detroit	Cotrulo, L. D.	Detroit	Dunn, Cornelius E.	Detroit
Canter, G. E.	Detroit	Cotton, S. O.	Detroit	Durocher, Edmund J.	Ecorse
Capano, Oreste A.	M	Coucke, Henry O.	M	Durocher, Normand E.	M
Caplan, Leslie	M	Coulter, Wm. J.	M	Dutchess, Charles E.	New York City
Caputo, Joseph M.	M	Cowan, Wilfrid	Detroit	Dwaihy, Paul	Detroit
Caraway, Jas. E.	M	Cowen, Leon B.	Detroit	Dwyer, Francis	M
Carbone, Louis A.	Detroit	Cowen, Robert L.	Detroit	Dysarz, T. T.	Detroit
Carey, Cornelius	Detroit	Coyne, Douglas Ruthven	Detroit	Dziuba, John F.	Detroit
Carleton, L. H.	Detroit	Craig, Henry R.	Eloise	Eades, Charles C.	M
Carlucci, Peter F.	Detroit	Crane, Langdon T.	Detroit	Eakins, Frederick J.	Berkley
Carmichael, E. K.	Detroit	Cree, Walter J.	(E) Detroit	Eaton, Crosby D.	Detroit
Carnes, Harry E.	M	Crews, Thomas H.	Detroit	Edgar, Russell G.	Detroit
Carney, John W.	M	Croll, L. J.	M	Eder, Joseph R.	M
Carp, Joseph	M	Cross, Harold E.	Detroit	Eder, Samuel J.	Detroit
Carpenter, C. H.	Detroit	Crossen, Henry F.	Detroit	Edgar, Irving I.	Detroit
Carpenter, C. J.	Detroit	Croughshore, J. E.	M	Edmonds, W. N.	Detroit
Carpenter, Glenn B.	Detroit	Cruikshank, Alexander	Detroit	Edwards, Gilbert Lloyd	Detroit
Carr, J. G.	Detroit	Culp, Ormond	M	Edwards, J. W.	Detroit
Carroll, E. H.	Detroit	Curhan, Jos. Howard	Detroit	Eisman, Clarence H.	Detroit
Carroll, Lona B.	Detroit	Curry, F. S.	Detroit	Elliot, Wm. G.	Detroit
Carson, Herman J.	Detroit	Curtis, Frank E.	Detroit	Ellis, Seth W.	M
Carstens, Henry R.	M	Cushing, Russell G.	Detroit	Elvidge, Robert J.	Detroit
Carter, John M.	Detroit	Cushman, H. P.	Detroit	Emmert, Herman C.	Detroit
Carter, L. F.	Detroit	Dale, Esther H.	Detroit	Engel, Earl H.	M
Cassidy, Wm. J.	Detroit	Dana, Harold M.	M	Ensign, Dwight C.	Detroit
Castrop, C. W.	Dearborn	Danforth, J. C.	Detroit	Ensing, Osborn	Detroit
Cathcart, Edward	M	Danforth, M. E.	Detroit	Epstein, S. G.	Detroit
Catherwood, Albert E.	Detroit	Daniels, L. E.	Detroit	Erickson, Eldon W.	Detroit
Caton, Dorothy	Detroit	Darling, Milton A.	Detroit	Erickson, Milton H.	Eloise
Caughy, Edgar H.	M	Darpin, Peter H.	Detroit	Erkfitz, Arthur W.	Detroit
Cavell, Roscoe Wm.	M	Davidow, David M.	Detroit	Erman, Joseph M.	Detroit
Cetlinski, C. A.	Hamtramck	Davidson, Harry O.	Detroit	Eschbach, Jos. W.	M
Chabut, V. George	Northville	Davies, Thos. S.	Grosse Pt.	Estabrook, Bert U.	Detroit
Cball, Henry G.	Detroit	Davies, Windsor S.	M	Ettinger, Clayton J.	Detroit
Chalat, Jacob H.	Detroit	Davis, Egbert F.	Wyandotte	Evans, Jos. M.	Detroit
Chance, J. H.	Detroit	Davis, George H.	M	Evans, Leland S.	Redford
Chapman, Aaron L.	Detroit	Davis, Lindon Lee	M	Evans, William A., Jr.	M
Chapman, Paul T.	Detroit	Dawson, F. E.	Inkster	Ewing, C. H.	M
Chapnick, H. A.	M	Dawson, Ralph W.	Detroit	Fallick, Mordecai Louis	M
Chase, Clyde H.	Detroit	Dawson, W. A.	Inkster	Falk, I. E.	Detroit
Chatel, Arthur N.	Detroit	Day, J. Claude	M	Fallis, Lawrence S.	Detroit
Chester, W. P.	Detroit	Defever, Cyril R.	M	Fandrich, Theodore	M
Chesluk, H. M.	M	Defnet, William A.	Detroit	Farbman, Aaron A.	Detroit
Childs, George Millard	M	DeGroat, Albert	M	Farbman, Simon S.	Detroit
Chipman, W. A.	Detroit	DeJongh, Edwin	Detroit	Fauman, David H.	Detroit
Chittenden, Geo E.	M	Delbert, Stewart G.	M	Faunce, Sherman P.	Detroit
Chittick, William R. (E)	San Diego, Cal.	Dempster, James H.	Detroit	Felcyn, W. George	Detroit
Chostner, G. C.	Detroit	DeNike, A. James	Detroit	Feld, David	Detroit
Christensen, C. A.	Dearborn	Denis, George M.	Detroit	Feldstein, Martin Z.	M
Christopher, James G.	Detroit	Denison, Louis L.	Detroit	Fellers, Ray L.	Detroit
Chrouch, Laurence A.	Detroit	De Ponio, Sylvester A.	Detroit	Fenech, Harold B.	M
Cioffari, Mario S.	Detroit	Derby, Arthur P.	Detroit	Fenner, Wm. A.	Detroit
Ciprian, Joseph E.	Detroit	Derleth, Paul E.	M	Fenton, E. H.	Detroit
Clark, Benjamin W.	M	DeSpelder, Ray E.	Detroit	Fenton, Meryl M.	M
Clark, C. M.	Detroit	DeTomasi, Rome Q.	Detroit	Fenton, Russell F.	Detroit
Clark, Donald V.	Detroit	Dibble, Harry F.	Detroit	Fenton, Stanley C.	Detroit
Clark, George E. (E)	Detroit	Dickman, Harry M.	M	Ferguson, Franklin F.	M
Clark, Harold E.	Detroit	Dickson, B. R.	Detroit	Ferrera, Louis V.	M
Clark, Harry G.	Detroit	Dickson, Elias L.	Detroit	Ferrara, Virginia M.	Detroit
Clark, Harry L.	Detroit	Diebel, Nelson W.	Detroit	Fettig, Carl A.	Grosse Pointe Park
Clark, Ronald E.	Detroit	Dietzel, H. O.	Detroit	Field, G. S. (E)	Detroit
Clarke, George L.	Detroit	Dill, Hugh L.	Detroit	Fine, Edward	Detroit
Clarke, Niles A.	M	Dill, J. Lewis	Detroit	Fischer, Frederick J.	M
Clarke, Norman E.	Detroit	DiLoreto, Panfilo, Camillo	M	Fisher, George S.	M
Clifford, C. H.	Detroit	Dittmer, Edwin	Detroit	Fisher, O. O.	Detroit
Clifford, John E.	Detroit	Dixon, Fred W.	M	Fisher, R. L.	Detroit
Clifford, Thomas P.	Detroit	Dixon, Ray S.	Detroit	Fitzgerald, E. W.	M
Clippert, J. C.	Grosse Ile	Dodds, John C.	Detroit	Fitzgerald, James M.	M
Coan, Glenn L.	Wyandotte	Dodenhoff, C. F.	Detroit	Flaherty, H. J.	Detroit
Coates, Carl Amos	Dearborn	Dodrill, F. D.	Ann Arbor	Flaherty, N. W.	M
Cobane, John H.	Detroit	Doerr, Louis E.	M	Flaherty, S. A.	Detroit
Cochrane, Edgar G.	Detroit	Dolega, Stanley F.	M	Fleming, L. N.	Detroit
Cohn, Daniel E.	M	Dolman, E. Nesbitt	Detroit	Flora, Wm. R.	M
Cohoe, Don A.	Detroit	Domzalski, C. A.	Detroit	Flower, J. A.	Detroit
Cole, Fred H.	Detroit	Donovan, Daniel R., Jr.	Detroit	Fogt, Herbert E.	Detroit
		Donovan, John D.	Dearborn	Fogt, Robert G.	Detroit

ROSTER 1945

Foley, Hugh S. Dearborn
Foley, Joseph M. Detroit
Font, Anthony J. Detroit
Foote, James A. Detroit
Ford, F. A. Detroit
Ford, George A. Detroit
Ford, Sylvester M.
Ford, Walter D. Detroit
Fordell, F. S. Detroit
Forrester, Alex V. Detroit
Forsythe, John R. M.
Foster, E. Bruce M.
Foster, Daniel P. Detroit
Foster, Linus J. Detroit
Foster, Owen C. Detroit
Foster, Wm. L. Detroit
Foster, W. M. Detroit
Fowler, Melvin E. Detroit
Fox, Morris Edward M.
Fraiberg, Paul L. Detroit
Franjac, M. J. Dearborn
Franzen, Nils A. Detroit
Fraser, Eldred E. Detroit
Fraser, Harvey E. M.
Frazier, Mary Margaret Detroit
Freedman, John M.
Freeman, D. K. Detroit
Freeman, Mabel Detroit
Freeman, Michael Detroit
Freeman, Thelma Detroit
Freeman, Wilmer Detroit
Freese, John A. Detroit
Freid, Samuel Detroit
Fremont, Joseph C. M.
Freund, Hugo A. Detroit
Fried, Bernard H. M.
Friedlaender, Alex S. Detroit
Friedman, I. H. Detroit
Frink, Norman W. Detroit
Frostic, William D. M.
Frothingham, Geo. E. (E) Detroit
Fruend, Henrietta Detroit
Fullenwider, Allan C. Detroit
Fuller, Hugh M. M.
Fulgenci, Andrew A. M.
Gaba, Howard M.
Gabe, Sigmund M.
Gaberman, David B. Detroit
Gaffney, J. Mitchell Detroit
Galantowicz, H. C. Detroit
Galdonyi, Laslo Detroit
Galdonyi, Nicholas Detroit
Galerneau, D. B. Center Line
Gamble, Parker B. Detroit
Gannan, Arthur M. Detroit
Ganschow, John H. Detroit
Garipey, L. J. Detroit
Garner, Howard B. (E) Detroit
Gaston, Herbert B. M.
Gates, Nathaniel H. Detroit
Gaynor, Alex Detroit
Gehring, Harold W. Detroit
Gehrke, August E. Detroit
Geib, Ledro O. Detroit
Geib, Wayne A. M.
Geiter, Clyde W. Detroit
Geitz, Wm. A. Detroit
Gelbach, Philip D. Detroit
Gellert, I. S. Detroit
Gemeroy, J. C. Detroit
Gerondale, Edmond J. Detroit
Gibson, James C. (E) Detroit
Giese, Fred W. M.
Gignac, Nicola Detroit
Gignac, Arthur L. Detroit
Gilbert, Harold R. Wyandotte
Gilbert, Roy S. Detroit
Gillman, R. W. (E) Detroit
Gingold, Samuel M. M.
Gingrich, Wayne A. M.
Ginsberg, Harold I. M.
Gitlin, Charles M.
Gitlin, Julius R. Detroit
Gittins, Perry C. Detroit
Glasgow, Gordon K. Detroit
Glassman, Samuel Detroit
Glazer, Walter S. Detroit
Gleason, John E. Detroit
Glees, J. L. Grosse Pointe Farms
Glemet, Raymond B. Detroit
Glickman, L. Grant M.
Glowacki, B. F. Detroit
Gmeiner, Clarence C. Detroit
Goerke, Elmer A. Romulus
Goetz, Angus G. M.
Goins, Wm. F. Detroit
Goldberg, Arthur Detroit
Goldberg, Harry H. Detroit
Goldberg, Nathan H. Detroit
Goldin, M. I. M.
Goldman, Perry M.
Goldsmith, Joseph D. Detroit

Goldstone, R. R. Detroit
Gollman, Maurice D. M.
Gonne, William S. Detroit
Good, William H. M.
Goodrich, B. E. M.
Gordon, William H. M.
Gorelick, Martin J. M.
Gorning, Raymond P. Detroit
Gottschalk, Fred W. Detroit
Gould, S. Emanuel Eloise
Goux, Raymond S. Detroit
Grace, Joseph M. Eloise
Graff, J. M. Detroit
Grain, Gerald O. Detroit
Grajewski, Leo E. Detroit
Gramley, William Detroit
Granger, Francis L. Detroit
Gratton, Henri L. Detroit
Gravelle, Lawrence J. Detroit
Green, Ellis R. Detroit
Green, Lewis Detroit
Green, Louis M. M.
Green, Nelson W. Detroit
Green, Simpson W. Detroit
Green, Sydney H. M.
Greenberg, Julius J. M.
Greenberg, Morris Z. M.
Greene, John B. Detroit
Greenidge, Robert Detroit
Greenlee, Wm. Tate Detroit
Greiner, Bert A. Detroit
Grekin, Joseph Detroit
Grekin, Samuel L. Detroit
Griffith, Arthur J. Detroit
Grillo, S. Phillip Belleville
Grimaldi, G. J. M.
Grinstein, Alexander Detroit
Grob, Otto Detroit
Gronow, A. A. Detroit
Grossman, Sol M.
Gruber, T. K. Eloise
Guimaraes, A. S. Dearborn
Gurdjian, E. S. Detroit
Gurman, Ben G. M.
Gutow, Benj. R. M.
Haeefe, Leslie P. Garden City
Hale, Arthur S. Detroit
Hall, Arche C. Detroit
Hall, E. Walter Detroit
Hall, James A. J. Detroit
Hall, Ralph E. Detroit
Hall, Robert J. Detroit
Haluska, Jos. A. Detroit
H'Amada, Norman K. Detroit
Hamburger, A. C. M.
Hamel, John Detroit
Hamil, Brenton M. Detroit
Hamilton, Norman C. Detroit
Hamilton, Stewart Detroit
Hamilton, William Detroit
Hamilton, William F. Detroit
Hammer, Charles A. Detroit
Hammer, Edwin J. Detroit
Hammer, Howard J. M.
Hammond, A. E. Detroit
Hammond, James L. Inkster
Hand, Fordus V. M.
Hanna, Carl M.
Hanna, E. Howard Detroit
Hanna, Samuel C. Detroit
Hansen, Frederick E. Detroit
Hanser, Joshua Detroit
Hanson, Frederick N. M.
Harellick, E. W. Detroit
Hardstaff, R. John Detroit
Hardy, George C. Detroit
Harley, Louis M. Detroit
Harm, W. B. Detroit
Harper, Jesse T. M.
Harrell, Voss Detroit
Harris, Harold H. M.
Harris, Ivor David Detroit
Harris, Landy E. Detroit
Harrison, Hugh Detroit
Harrison, Wesley Detroit
Hart, Charles E. M.
Hart, J. Clarence M.
Hartgraves, Hallie Detroit
Hartman, F. W. Detroit
Hartmann, W. B. Detroit
Hartzell, John B. M.
Hasley, Clyde K. Detroit
Hasley, Daniel E. Detroit
Hastings, Orville J. Detroit
Hause, Glen E. M.
Hauser, I. Jerome M.
Hauser, John E. Detroit
Havers, Howard Detroit
Hawkins, James W. Detroit
Hayes, Joseph D. Detroit
Heath, Leonard P. M.
Heath, Parker Detroit

Heavner, L. E. M.
Hedgeman, E. Chester Detroit
Hedges, Frank W. Detroit
Hedrick, Donald W. Detroit
Heenan, T. H. Detroit
Heideman, Louis M.
Heldt, Thomas J. Detroit
Hendelman, Manuel H. Detroit
Henderson, A. B. M.
Henderson, Harold Detroit
Henderson, J. L. Detroit
Henderson, Leslie T. Detroit
Henderson, William E. Detroit
Henderson, Wm. W. M.
Henig, Fred M.
Henrich, L. E. Detroit
Herkimer, Dan R. M.
Herrold, Rose E. Detroit
Herschelmann, Roy F. M.
Hershey, Lynn N. Detroit
Hewitt, Leland V. Detroit
Hewitt, Robt. S. M.
Heyner, Stanley A. Detroit
Hibbard, Ralph G. Detroit
Hickey, Joseph Detroit
Higbee, Arthur L. Detroit
Hildebrandt, Hugh R. Detroit
Hilleman, Lee Ecorse
Hillenbrand, Alfred E. M.
Hiller, Glenn I. Detroit
Hilton, William E. Detroit
Hinko, Edward N. Eloise
Hipp, William Detroit
Hirshfeld, John W. Detroit
Hirschman, L. J. Detroit
Hochman, Morton M. Detroit
Hodges, Roy W. Detroit
Hodgkinson, C. P. M.
Hodoski, Frank J. Detroit
Hoening, Andrew L. Detroit
Hoffman, E. S. Detroit
Hoffman, Henry A. M.
Hoffmann, Martin H. Detroit
Holcomb, August A. Northville
Hollander, A. J. Detroit
Hollis, Henry B. Detroit
Holman, Herbert H. M.
Holmes, A. W. Detroit
Holt, Henry T. Detroit
Holstein, A. P. M.
Honhart, Fred L. Detroit
Honor, William H. Wyandotte
Hooker, Donald H. M.
Hookey, J. A. M.
Hooper, Norman L. Detroit
Hoopes, Benjamin F. M.
Hoops, George B. Detroit
Hopkins, J. E. Detroit
Horan, Thomas M.
Horkins, Harold A. Detroit
Horny, Hugo M.
Horton, Reece H. Detroit
Horvath, Louis O. Detroit
Horwitz, John B. M.
Host, Lawrence N. Detroit
Hotchkiss, Loris M. Farmington
Howard, Austin J. Detroit
Howard, Philip J. Detroit
Howell, Bert F. Detroit
Howes, Willard Boyden Detroit
Howlett, Howard T. Detroit
Hromadko, Louis Detroit
Hubbard, John P. Detroit
Hudson, A. Willis Detroit
Hudson, J. Stewart Grosse Pointe
Hudson, Wm. A. Detroit
Huegli, Wilfred A. M.
Huff, Reginald G. Wayne
Hughes, Albert A. Detroit
Hughes, Ray W. Detroit
Hull, L. W. Detroit
Hunt, T. H. Detroit
Hooker, Donald H. M.
Hunt, Verne G. Detroit
Hunter, Basil H. Detroit
Hunter, C. M. Detroit
Hunter, Elmer N. Detroit
Husband, Chas. W. Detroit
Hussey, Raymond Detroit
Hyatt, Jarvis M. M.
Hyde, F. W. Detroit
Iacobelli, Peter H. M.
Ignatius, A. A. Detroit
Ihle, Lyman E. M.
Igna, Eli J. Detroit
Insley, Stanley W. Detroit
Irvin, Earle Albert Detroit
Irwin, W. A. Detroit
Israel, Barney B. M.
Israel, J. G. Detroit
Isaacson, Arthur Detroit
Ivkovich, Peter M.
Jacobson, Samuel D. Detroit

ROSTER 1945

Jacoby, Myron D.	Detroit	King, Edward D.	Detroit	Lentine, James J.	M
Jaeger, Grove A.	Detroit	King, Melbourne J.	M	Lenz, Willard R.	Grosse Pointe
Jaeger, Julius P.	Detroit	Kingswood, Roy C.	Detroit	Lepard, C. W.	Detroit
Jaekel, C. N.	Detroit	Kirchner, Augustus.	Detroit	Lepley, Fred O.	Detroit
Jaffar, Donald J.	Detroit	Kirker, J. G.	Detroit	Lerman, S. E.	Centerline
Jaffe, J. L.	Detroit	Klebba, Paul.	Detroit	Lescohier, Alex W.	Grosse Pointe
Jaffe, Jacob.	Detroit	Klein, Wm.	Detroit	L'Esperance, Simon P.	Detroit
Jaffe, Louis.	M	Kliger, David.	Detroit	Leszynski, J. S.	Detroit
Jahsman, William E.	Detroit	Kline, Lewis LeRoy.	Detroit	Leucutia, Traian.	Detroit
James, Richard G.	Detroit	Kline, Starr L.	Detroit	Levant, Arthur B.	M
Jamieson, Robert C.	Detroit	Klosowski, Joseph.	Detroit	Levin, David M.	M
Jamieson, Thomas J.	Lincoln Park	Klote, M. D.	Detroit	Levin, Michael M.	M
Janicki, Natalia J.	Eloise	Knaggs, Charles W.	Grosse Pointe	Levin, Samuel J.	Detroit
Jarre, Hans A.	Detroit	Knaggs, Earl J.	M	Levine, Sidney S.	M
Jarzynka, Frank J.	Dearborn	Knapp, Byron S.	M	Levitt, Edward.	Detroit
Jaison, Lawrence J.	M	Knapp, Floyd.	Detroit	Levitt, Nathan.	Detroit
Jend, William J.	Detroit	Knobloch, Edmund J.	Detroit	Levy, Marvin B.	Detroit
Jenkins, E. A.	M	Knoch, Hubert S.	M	Lewis, Charles T.	Detroit
Jenne, Byron H.	Detroit	Knox, Ross M.	Ecorse	Lewis, L. A.	Detroit
Jennings, Alpheus F.	Detroit	Koebel, R. H.	Detroit	Lewis, J. Hugh.	M
Jennings, Robert M.	M	Koerber, Edward J.	Detroit	Lewis, Wilfred John.	M
Jentgen, Chas. J.	Detroit	Koessler, George L.	Detroit	Libbrecht, Robert V.	Dearborn
Jentgen, L. G.	Detroit	Kohn, A. Max.	M	Lichter, M. L.	M
Jewell, F. C.	Detroit	Kohn, M. E.	Detroit	Lichtwardt, Hartman A.	Detroit
Jocz, M. W.	Grosse Pointe Park	Kokowicz, Raymond J.	M	Lieberman, B. L.	Detroit
Jodar, E. O.	Detroit	Kolasa, W. B.	Detroit	Liddicoat, A. G.	Detroit
John, Hubert R.	Detroit	Kopel, Joseph O.	Detroit	Lightbody, James J.	Detroit
Johnson, Elizabeth.	Detroit	Korby, George J.	Detroit	Lignell, Rudolph.	Detroit
Johnson, H. Peyton.	Detroit	Kosanovic, Frederick.	M	Lilly, Charles J.	Detroit
Johnson, Homer L.	Detroit	Koss, Frank R.	M	Lilly, Vernon S.	Detroit
Johnson, Ralph A.	Detroit	Kossayda, Adam W.	M	Linton, James R.	Eloise
Johnson, V. P.	Detroit	Koster, Koert.	Detroit	Lipinski, Stanley L.	Detroit
Johnson, Vincent C.	Detroit	Kovan, Dennis D.	M	Lipkin, Ezra.	Detroit
Johnson, W. H. M.	Detroit	Koven, Abraham.	Detroit	Lippold, Paul H.	Detroit
Johnston, Charles G.	Detroit	Kozlinski, Anthony E.	M	Lipschutz, Louis S.	M
Johnston, Everett V.	Detroit	Kraft, Raymond B.	Detroit	Littlejohn, David.	Dearborn
Johnston, J. A.	Detroit	Kraft, Ruth M.	Detroit	Livingston, George D.	M
Johnston, John L.	Detroit	Krass, Edward W.	M	Livingston, Geo. M.	(R) Detroit
Johnston, Wm. E.	Detroit	Kraus, John J.	Detroit	Lockwood, Bruce C.	Detroit
Johnstone, B. I.	Detroit	Krebs, William T.	Detroit	Lofstrom, James E.	M
Joiville, E. V.	Detroit	Kreinbring, George E.	Detroit	Long, Earle C.	Detroit
Jones, Arthur J.	Detroit	Kretschmar, Clarence A.	Detroit	Long, John J.	Detroit
Jones, Adrian R.	Detroit	Krieg, Earl G.	Detroit	Loranger, C. B.	Grosse Pointe
Jones, Edna M.	Northville	Krieger, Harley L.	Detroit	Loranger, Guy L.	M
Jones, H. C.	M	Kritchman, M. J.	Detroit	Lorber, Joseph H.	M
Jones, L. Faunt.	Detroit	Kroha, Lawrence.	Detroit	Lorentzen, Edwin H.	Detroit
Jones, Roy D.	Detroit	Krohn, Albert H.	Detroit	Lovas, W. S.	M
Jonikaitis, Joseph J.	Detroit	Krynicky, Francis X.	Detroit	Love, W. Thomas.	Detroit
Joyce, Stanley J.	M	Kubaneck, Joseph L.	Eloise	Lovell, B. K.	M
Judd, C. Hollister.	Detroit	Kucmierz, Francis S.	M	Lovering, Wm. J.	Detroit
Juliar, Benjamin.	M	Kuhn, Albert Arthur.	M	Lowrie, G. B.	Detroit
Jurow, Harry N.	Detroit	Kuhn, Richard F.	M	Lowrie, Wm. L.	Detroit
Kallet, Herbert I.	Detroit	Kulaski, Chester H.	Detroit	Lowry, George L.	Detroit
Kallman, David.	Detroit	Kullman, Harold J.	M	Luce, Henry A.	Detroit
Kallman, Leo.	Detroit	Kurcz, J. A.	M	Lum, Thomas Kion.	M
Kallman, R. Robert.	M	Kurtz, I. J.	Detroit	Lutz, Earl F.	Detroit
Kaminski, L. R.	Detroit	Kwasiborski, S. A.	Wyandotte	Lynn, David H.	Detroit
Kaminski, Zeno L.	Detroit	Laberge, James M.	M	Lynn, Harvey D.	Detroit
Kamperman, George A.	Detroit	LaBine, Alfred C.	Detroit	Lyons, William Harrington.	Detroit
Kanter, Herman.	M	LaCore, Ivan.	M	Mabee, Frank P.	Detroit
Kapetansky, A. J.	Detroit	LaFerte, Alfred D.	Detroit	Mabley, J. Donald.	M
Kapetansky, N. J.	Detroit	Lakoff, Charles.	Detroit	MacArthur, Robert A.	Detroit
Kaplita, Walter A.	M	Lam, Conrad R.	Detroit	MacCracken, Frances L.	Detroit
Karr, Herbert S.	Detroit	Lamberson, Frank A.	Detroit	MacDonald, James.	Detroit
Kasaback, V. Y.	Detroit	LaMarche, N. O.	Detroit	MacDougall, Orrin P.	Detroit
Kasper, Joseph A.	Detroit	Lammy, James V.	Detroit	MacFarlane, Howard W.	Detroit
Kass, Arnold.	Detroit	Lampman, H. H.	Detroit	MacGregor, W. W.	Detroit
Kass, J. B.	Detroit	Landers, M. B.	Detroit	Mack, Harold C.	M
Kates, Simon C.	Detroit	Landers, M. B., Jr.	Dearborn	MacKenzie, Earle D.	Detroit
Katzman, I. S.	Detroit	Lang, Leonard W.	Detroit	MacKenzie, Frank M.	Detroit
Kauffman, Wm.	M	Lange, Anthony H.	Detroit	Mackenzie, John W.	Grosse Pointe
Kaump, Donald H.	Detroit	Lange, Wm. A.	M	Mackenzie, W. G.	Detroit
Kauppinen, J. A.	Detroit	Laning, George M.	Detroit	MacMillan, Francis B.	Detroit
Kay, Edward W.	Hamtramck	Lansky, Mandell.	M	MacMillan, James M.	M
Kay, Harry H.	M	Lapham, Fred E.	M	MacMullen, Frank B.	Detroit
Kazdan, Louis.	M	LaRocco, Anthony J.	Detroit	MacQueen, Malcolm D.	Detroit
Kazdan, Morris A.	M	Lasley, James Wm.	Detroit	MacPherson, K. C.	Detroit
Keane, Wm. E.	Detroit	Lassaline, S. J.	Detroit	Maczewski, John E.	Detroit
Kearns, Hubert J.	Detroit	Lathrop, Philip L.	Detroit	Madsen, Martha.	Detroit
Keating, Thomas F.	Detroit	Laub, Stanley V.	M	Magnell, Ralph C.	Detroit
Keene, Clifford H.	M	Lauppe, Edward H.	Detroit	Maguire, Clarence E.	Detroit
Kehoe, Henry J.	East Detroit	Lauppe, F. A.	M	Mahlatjie, Nathaniel M.	Detroit
Kelly, Edward W.	Detroit	Law, John H.	Detroit	Mahoney, Hugh M.	Detroit
Kemler, W. J.	Ecorse	Lawrence, Wm. C.	Detroit	Maibauer, F. P.	M
Kennary, James M.	Detroit	Lazar, Morton R.	M	Major, Roman H.	Hamtramck
Kennedy, Chas. S.	Detroit	Leach, David.	M	Maire, E. D.	M
Kennedy, L. F.	Detroit	Leacock, Robert C.	Detroit	Mair, Harold U.	M
Kennedy, Robert B.	Detroit	Leader, L. R.	Detroit	Malachowski, B. T.	Detroit
Kennedy, Wm. Y.	Detroit	Leaver, L. Ross.	Detroit	Malik, Edward A.	Detroit
Kern, W. H.	Garden City	Leckie, George C.	Detroit	Malik, Nur M.	Detroit
Kernkamp, Ralph.	Detroit	Ledwidge, Patrick L.	Detroit	Malina, Stephen.	Detroit
Kernick, Melvin O.	M	Lee, Harry E.	Detroit	Malone, Herbert.	Detroit
Kersten, Armand G.	Detroit	LeGallee, George M.	M	Maloney, John A.	Detroit
Kersten, Werner.	Detroit	Lehman, William L.	M	Mancuso, Vincent S.	Detroit
Kerzman, Joseph H.	Detroit	Leibinger, H. R.	Detroit	Mandiberg, Jack N.	M
Keshishian, Sarkis K.	Detroit	Leipsitz, Louis S.	M	Manning, Morey H.	Detroit
Keyes, Eugene Charles.	Dearborn	Leiser, Rudolf.	Eloise	Maples, Douglas E.	M
Keyes, John W.	M	Leithauser, D. J.	Detroit	Marcotte, Oliver.	Detroit
Kibzey, Ambrose T.	Detroit	Leland, Sol.	M	Marcus, Daniel B.	Detroit
Kidner, Frederick C.	Detroit	Lemley, Clark.	Detroit	Marinus, Carleton J.	Detroit
Kimball, David C.	M	Lemmon, Charles E.	M	Marion, Donald F.	M
Kimberlin, Kenneth K.	M	Lemmon, Clarence W.	River Rouge	Mark, Jerome.	M

ROSTER 1945

Markoe, Rupert C. L.....Detroit
Marks, Ben.....M
Marks, Morris.....Detroit
Marsden, Thomas B.....Detroit
Marsh, Alton R.....Detroit
Marshall, James R.....Detroit
Martin, Edward G.....Detroit
Martin, Elbert A.....Detroit
Martin, I. Herbert.....Detroit
Martin, J. B., Jr.....Detroit
Martin, L. R.....Detroit
Martin, R. M.....Detroit
Martinez, P. O.....Detroit
Martner, Edgar.....M
Marwil, T. B.....M
Mason, Percy W.....Detroit
Massengile, Cleave.....Detroit
Mateer, John G.....Detroit
Mathes, Charles J.....Saginaw
Maun, Mark E.....Detroit
Maxwell, J. Harvey.....Detroit
May, Earl W.....Detroit
May, Frederick T., Jr.....M
Mayer, Willard D.....Detroit
Mayne, C. H.....Detroit
McAfee, F. W.....Detroit
McAlonan, Wm. T.....Detroit
McAlpine, A. D.....Detroit
McAlpine, Gordon S.....Detroit
McBroom, Russell E.....Detroit
McClellan, G. L.....Detroit
McClellan, Robert J.....Detroit
McClendon, James J.....Detroit
McClintock, J. J.....Detroit
McClure, Robert W.....M
McClure, Roy D.....Detroit
McClure, Wm. R.....Detroit
McColl, Charles W.....M
McColl, Clarke M.....Detroit
McColl, Kenneth M.....Detroit
McCollum, E. B.....M
McCord, Carey P.....Detroit
McCormick, Colin C.....Dearborn
McCormick, C. W.....Detroit
McCormick, F. T.....Detroit
McCullough, Lester E.....Detroit
McDonald, Angus L.....Detroit
McDonald, George O.....Detroit
McDonald, Grant.....Detroit
McDonald, Peter W.....Wyandotte
McEvitt, Wm. G.....Detroit
McGarvah, A. W.....Detroit
McGarvah, Jos. A.....Detroit
McGee, Charles Joseph.....Eloise
McGillicuddy, Walter E.....Detroit
McGinnis, Daniel H.....Detroit
McLaughlin, Nicholas D.....M
McGough, Joseph M.....M
McGraw, Arthur B.....M
McGuire, M. Ruth.....Detroit
McIntosh, W. V.....Detroit
McKean, G. Thomas.....M
McKean, Richard M.....M
McKenna, Charles J.....M
McKhann, Charles F.....Detroit
McKinnon, John D.....Detroit
McLane, Harriet E.....Detroit
McLean, Don W.....M
McLean, Harold G.....Detroit
McMahon, Gerald H.....Detroit
McMehen, Chas. E.....Berkeley
McPherson, E. Glenn.....Dearborn
McPherson, R. J.....Detroit
McQuiggan, Mark R.....Detroit
McQuiggan, Paul.....M
McRae, Donald H.....Detroit
Mead, John.....Detroit
Meader, F. M.....Kalamazoo
Meek, Stuart F.....New Baltimore
Meinecke, Helmuth A.....Detroit
Mellen, Hyman S.....Detroit
Menagh, Frank R.....Detroit
Mendelssohn, R. J.....Detroit
Merkel, Charles C.....Grosse Pointe
Merrill, Wm. O.....Detroit
Merriman, K. S.....Detroit
Merritt, Earl G.....Detroit
Metzger, Harry C.....Detroit
Meyer, Ruben.....Detroit
Meyers, M. P.....M
Meyers, Solomon G.....M
Milley, H. H.....Detroit
Miller, Daniel H.....Detroit
Miller, Harry A.....M
Miller, Hazen L.....Detroit
Miller, Karl.....M
Miller, Maurice P.....Trenton
Miller, Myron H.....Detroit
Miller, T. H.....M
Miller, Wm. Ernest.....Detroit
Mills, Clinton C.....M

Mills, Georgia V.....Detroit
Milton, Boynton A.....Inkster
Mintz, Edward I.....Detroit
Miral, Solomon P.....Detroit
Mishelevich, Sophie.....Detroit
Mitchell, C. Leslie.....Detroit
Mitchell, Gertrude F.....Detroit
Mitchell, Ralston S.....Detroit
Mitchell, W. Bede.....M
Moehlig, Robert C.....Detroit
Moisides, V. P.....Detroit
Moll, Clarence D.....Detroit
Molner, Joseph G.....M
Moloney, J. Clark.....M
Mond, Edward.....Detroit
Monfort, Willard.....Detroit
Montgomery, John C.....Detroit
Montante, Jos. R.....M
Moore, Doris Sanders.....Detroit
Moore, James A.....Detroit
Moore, Milridge B.....Detroit
Morand, Louis J.....Detroit
Morgan, Donald Nye.....M
Moriarity, George.....Detroit
Moritz, H. C.....Detroit
Morley, Harold V.....M
Morley, James A.....Detroit
Moroun, S. J.....Detroit
Morris, Harold L.....Detroit
Morrison, Marjorie G. E.....Detroit
Morse, Ellen.....Detroit
Morse, Plinn F.....Detroit
Morton, David G.....M
Morton, John B.....Detroit
Mosee, W. Jones.....Detroit
Mosen, Max M.....Detroit
Moss, E. B.....Detroit
Moss, Nathan H.....Detroit
Mott, Carlin P.....Detroit
Moyer, Carl A.....Eloise
Muellenhagen, Walter J.....Detroit
Munson, F. T.....Detroit
Muntvan, Andrew.....Detroit
Murphy, D. J.....M
Murphy, Frank J.....M
Murphy, John M.....M
Murphy, Scipio G.....Detroit
Murphy, W. M.....Detroit
Murray, George M.....Detroit
Murray, William A.....Detroit
Muske, Paul H.....M
Myers, George P.....Detroit
Nagel, Oscar.....M
Nagle, John W.....Wyandotte
Naud, Henry I.....Detroit
Nawotka, E. E.....Detroit
Naylor, A. E.....Detroit
Naylor, Arthur H.....Detroit
Neeb, Walter G.....M
Nelson, Harry M.....Detroit
Nelson, Victor E.....M
Neumann, Arthur I.....Detroit
Newbair, Arthur A.....Detroit
Newman, Max Karl.....Detroit
Nielsen, Aage E.....M
Nichamin, Samuel J.....M
Nickels, Albert W.....M
Nickerson, Ivey Dean.....M
Nigro, Norman D.....M
Nill, John B.....Detroit
Nill, William F.....Detroit
Nixdorf, Wallace B.....Detroit
Noer, Rudolf I.....M
Nolan, Bernard E.....Detroit
Nolting, Wilfred S.....M
Norconk, A. A.....M
Norris, Edgar H.....Detroit
Northrop, Arthur K.....Detroit
Norton, A. B.....Detroit
Norton, Charles S.....Detroit
Noth, Paul H.....Grosse Pointe Farms
Novy, R. L.....Detroit
Nowicki, Joseph A.....Detroit
O'Brien, E. J.....Detroit
O'Brien, G. M.....Detroit
O'Donnell, Charles.....Dearborn
O'Donnell, David H.....(E) Detroit
O'Donnell, Dayton H.....M
Ohmart, Galen B.....Detroit
O'Hara, James T.....Detroit
Ohr, Harold F.....Detroit
Olenikoff, Alex.....M
Olechowski, Leo W.....M
Olmsted, William R.....Detroit
Olney, H. E.....Detroit
Oman, Cyrus F.....Detroit
Oppenheim, J. M.....M
Oppenheim, Milton M.....Highland Park
Organ, Fred W.....Detroit
Ormond, John K.....Detroit
Orecklin, L.....Detroit
Ornstein, Charles.....Detroit

O'Rourke, Paul V.....Detroit
O'Rourke, R. M.....Detroit
Osius, Eugene A.....M
Ott, Harold A.....M
Ottaway, John P.....M
Owen, Clarence I.....M
Palmer, Alice.....Detroit
Palmer, Hayden.....Detroit
Palmer, R. Johnston.....Detroit
Pangburn, L. E.....Detroit
Panic, Stephen M.....Detroit
Panzner, Edward J.....Detroit
Parker, Benjamin R.....M
Parker, Walter R.....(E) Detroit
Parr, R. W.....Detroit
Parsons, John P.....Grosse Pointe Park
Pasternacki, Norbert T.....Detroit
Paterson, Walter G.....Detroit
Patton, Henry S.....M
Pawlowski, Jerome.....Detroit
Paysner, Harry A.....Detroit
Peabody, Chas. Wm.....M
Peacock, Lee W.....Detroit
Pearman, Charles L. R.....Detroit
Pearse, Harry A.....Detroit
Peggs, George F.....M
Peirce, Howard W.....Detroit
Penberthy, G. C.....M
Pendy, John M.....M
Pensler, Meyer.....M
Pequegnot, Chas. F.....Detroit
Perdue, Grace M.....Detroit
Perkin, Frank S.....M
Perkins, Ralph A.....Detroit
Perlis, H. L.....Detroit
Perry, Alvin LaForge.....M
Peterman, Earl A.....Detroit
Petix, Samuel C.....Detroit
Pevin, Pauline.....Detroit
Pfeiffer, Rudolph L.....Detroit
Pickard, Orlando W.....Detroit
Pierce, Frank L.....Detroit
Pierston, Max J.....Detroit
Pietraszewski, A. W.....Detroit
Pinckard, Karl G.....Dearborn
Pink, Rose M.....Detroit
Pinney, Lyman J.....Detroit
Pino, Ralph H.....Detroit
Piper, Clark C.....Detroit
Piper, Ralph R.....Detroit
Pittman, J. E.....Detroit
Plagemeyer, H. W.....Detroit
Pliskow, Harold.....M
Podezwa, J. W.....M
Pollock, John J.....Detroit
Pool, Walter D.....Detroit
Poole, Marsh W.....M
Poos, Edgar E.....Detroit
Porretta, Anthony C.....Detroit
Porretta, F. S.....Detroit
Porter, Howard J.....Romulus
Portnoy, Harry.....Detroit
Posner, Irving.....Detroit
Potts, E. A.....Detroit
Pratt, Jean P.....Detroit
Pratt, Lawrence.....M
Prendergast, John J.....Detroit
Priborsky, Benj. H.....Detroit
Price, A. H.....Detroit
Price, Alvin Edwin.....M
Proctor, Bruce.....Grosse Pointe Farms
Proud, Robert H.....Flat Rock
Ptolemy, H. H.....Detroit
Pugliesi, Benedetto.....Detroit
Purcell, Frank H.....Detroit
Putra, A. M.....M
Quigley, William.....Detroit
Rabinovitch, Bella.....Detroit
Rahm, Lambert P.....M
Raiford, Frank P.....Detroit
Rand, Morris.....Detroit
Rao, John O.....Detroit
Raskin, John.....Detroit
Raskin, Morris.....Detroit
Rastello, Peter B.....Detroit
Ratigan, C. S.....Dearborn
Raynor, Harold F.....Detroit
Reberdy, George J.....Detroit
Reed, H. Walter.....Detroit
Reed, Ivor E.....Detroit
Rees, Howard C.....Detroit
Reid, Wesley G.....M
Reiff, Morris V.....M
Reinbolt, Chas. A.....Detroit
Reinsh, Ernest R.....M
Reisman, Nathan J.....Detroit
Rekshaw, W. R.....M
Renaud, G. L.....(E) Detroit
Rennell, Leo P.....Detroit
Renz, Russell H.....Detroit
Reske, Alven.....M
Reveno, William S.....Detroit

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Rexford, W. K.	Detroit	Schaeffer, Martin	Detroit	Skrzycki, Stephen S.	Detroit
Reye, H. A.	Detroit	Schembeck, I. S.	Detroit	Skully, E. J.	Detroit
Reynier, C. E.	Detroit	Schenden, A. J.	Melvindale	Sladen, Frank J.	Detroit
Reynolds, Lawrence	Detroit	Schiller, A. E.	Detroit	Slate, Raymond N.	Detroit
Reynolds, R. P.	Detroit	Schilling, Charles E.	Detroit	Slaughter, Fred M.	Detroit
Rezanka, Harold J.	Grosse Pointe	Schillinger, Harold K.	Dearborn	Slaughaupt, J. G.	Detroit
Rhoades, F. P.	Detroit	Schinagel, Geza	Detroit	Slazinski, Leo W.	Detroit
Rice, Clair M., Jr.	M	Schirack, Ray	Detroit	Slipson, Edith	Detroit
Rice, Harold B.	Detroit	Schlacht, George F.	Romulus	Slevin, John G.	Detroit
Rice, Meshel	Oxford	Schlafer, Nathan H.	Detroit	Sliwin, Edward P.	M
Richards, R. Milton	Detroit	Schlemer, John H.	Detroit	Small, Henry	M
Richardson, Allan L.	Detroit	Schmidt, Harry E.	M	Smeck, Arthur R.	Detroit
Richardson, Robert P.	Wayne	Schmidt, J. Robert	M	Smeltzer, Merrill	M
Rick, Paul J.	Detroit	Schmidt, Milton R.	M	Smith, Charles E.	Detroit
Ridge, Ralph W.	Wyandotte	Schmier, Burton L.	Detroit	Smith, Clarence V.	Detroit
Rieckhoff, George G.	Detroit	Schmitt, Norman L.	Detroit	Smith, Claude A.	River Rouge
Rieger, John B.	Detroit	Schneck, R. J.	Detroit	Smith, Clement A.	Detroit
Rieger, Mary H.	Detroit	Schneider, Curt P.	M	Smith, F. Janney	Detroit
Riseborough, E. C.	Detroit	Schoenfeld, Gilbert D.	Detroit	Smith, Fred R.	M
Rizzo, Frank	Detroit	Schorr, Robert L.	(E) Detroit	Smith, Gerrit Calvin	Detroit
Robb, Edw. L.	Detroit	Schooten, Sarah S.	Detroit	Smith, Henry L.	Detroit
Robb, Herbert F.	Belleville	Schreiber, Frederick	Detroit	Smith, J. Allen	M
Robb, J. M.	Detroit	Schroeder, Carlisle F.	M	Smith, James A.	Detroit
Robbins, Edward R.	Detroit	Schulte, Carl H.	Detroit	Smith, J. Campbell	Lake Worth, Fla.
Roberts, Arthur J.	Ecorse	Schultz, Ernest C.	Detroit	Smith, Vine LaRue	Detroit
Robins, Samuel C.	Detroit	Schultz, Robert F.	M	Smyth, Charley J.	Eloise
Robinson, Edwin L.	Detroit	Schwartz, Ben.	Detroit	Snedeker, Bernard C.	M
Robinson, Fred L.	Dearborn	Schwartz, H. Allen	Detroit	Snow, L. W.	Northville
Robinson, George W.	Detroit	Schwartz, Louis A.	M	Snyder, Arthur M.	Detroit
Robinson, Harold A.	M	Schwartz, Marvin	Detroit	Sobin, D. J.	Detroit
Robinson, R. G.	Detroit	Schwartz, Oscar D.	M	Socall, Charles J.	M
Rogers, A. Z.	Grosse Pte. Woods	Schwartzberg, Jos. A.	M	Sokolow, Raymond A.	M
Rogers, James D.	Wyandotte	Schweigert, C. F.	M	Somers, Donald C.	M
Rogin, James R.	Detroit	Sciarrino, Stanley V.	Detroit	Sonda, Lewis P.	Detroit
Rogoff, A. S.	M	Scott, R. J.	M	Sorock, Milton L.	M
Rohde, Paul C.	Detroit	Scott, William J.	Grosse Pte. Farms	Spademan, Loren C.	Detroit
Roland, Charles F.	Detroit	Scruton, Foster D.	Detroit	Spalding, Edward D.	M
Roman, Stanley J.	M	Seabury, Frank P.	Detroit	Sparling, Harold I.	M
Roney, Eugene H.	M	Secord, Eugene W.	Detroit	Sparling, Irene L.	Northville
Root, Charles T.	M	Seeley, James B.	Dearborn	Speck, Carlos C.	Allen Park
Rosbolt, Oscar P.	Detroit	Seeley, Ward F.	Detroit	Spector, Maurice J.	M
Rose, Bernard	Detroit	Segar, Lawrence F.	Detroit	Spero, Gerald D.	Detroit
Rosefield, John L.	Detroit	Seibert, Alvin H.	Grosse Pte. Park	Sperry, Frederick L.	Detroit
Rosen, Robert	Detroit	Selferlein, Archie L.	M	Sprio, Adolph	M
Rosenberger, Homer	M	Selby, C. D.	Detroit	Springborn, B. R.	Detroit
Rosenthal, Louis H.	M	Sellers, Charles W.	Detroit	Sprunk, Carl	M
Rosenzweig, Saul	Detroit	Sellers, Graham	Detroit	Sprunk, John P.	Detroit
Ross, D. G.	Grosse Pointe	Selling, Lowell	Detroit	Spurrier, Ethelbert	M
Ross, Ben C.	M	Selman, J. H.	Detroit	Squires, W. H.	Eloise
Ross, Hyman	M	Sewell, George	Detroit	Stafford, Claude M.	Detroit
Ross, Samuel H.	M	Seymour, William J.	Detroit	Stafford, Frank W. J.	Detroit
Roth, Edward T.	Detroit	Shafarman, Eugene	Detroit	Stageman, John Condon	M
Roth, Theodore I.	M	Shaffer, Jos. H.	M	Stalker, Hugh	Grosse Pointe
Rotarius, E. M.	Detroit	Shaffer, Loren W.	Detroit	Stamell, Meyer	M
Rothbart, H. B.	Detroit	Shaffer, Royce R.	Detroit	Stamos, Harry F.	Detroit
Rothman, Emil D.	Detroit	Shanoski, Stanley J.	Detroit	Stanton, James M.	Detroit
Rottenberg, Leon	M	Shapiro, Oscar U.	Detroit	Stanton, Myron	Detroit
Rowell, Robert C.	M	Shapiro, Reuben I.	M	Stapleton, Wm. J., Jr.	Detroit
Rowell, Wilfred J.	M	Sharp, Martin C.	Detroit	Starrs, Thomas C.	Detroit
Rubright, LeRoy W.	M	Sharrer, Chas. H.	Detroit	Steele, Hugh	Detroit
Rucker, Julian J.	Detroit	Shaw, Robert G.	Detroit	Stefani, E. L.	Detroit
Rueger, Milton J.	M	Shawan, Harold K.	Detroit	Stefani, Raymond T.	M
Rueger, Ralph C.	Detroit	Shebasta, Emil	M	Steffes, Everett M.	M
Runge, Edward F.	Detroit	Sheldon, John A.	Detroit	Stein, Albert H.	M
Rupprecht, Emil F.	M	Shelton, C. F.	M	Stein, Emory	M
Ruskin, Samuel	Detroit	Sheppard, Emma L. W.	Detroit	Stein, James R.	Ferndale
Ruskin, I. W.	Detroit	Sheppard, William B.	M	Stein, Saul C.	M
Russell, John C.	Detroit	Sherman, B. B.	Detroit	Steinbach, Henry B.	Detroit
Ryan, Charles F.	Detroit	Sherman, Louis L.	Detroit	Steinberger, Eugene	Detroit
Ryan, W. D.	Detroit	Sherman, Wm. L.	Detroit	Steiner, Gabriel	Detroit
Rydzewski, Jos. B.	Detroit	Sherrin, Edgar R.	M	Steiner, Louis J.	Detroit
Ryerson, Frank L.	Detroit	Sherwood, DeWitt L.	Detroit	Steiner, Max	M
Sachs, Herman K.	M	Shewchuk, Alexander P.	M	Steinhardt, Milton J.	M
Sack, A. G.	M	Shields, Wm. L.	Detroit	Stellhorn, Chester E.	Detroit
Sadi, Luth	Grosse Pointe	Shifrin, Peter G.	M	Stellhorn, Mary Christine	Detroit
Sadowski, Roman	Detroit	Shipton, W. Harvey	Detroit	Sterling, Lawrence	Detroit
Sage, Edward O.	Detroit	Shalain, Benjamin	Detroit	Sterling, Robert R.	Detroit
Sage, Thomas	Detroit	Shore, O. J.	Detroit	Stern, Edward A.	Detroit
Sager, E. L.	Detroit	Shorney, Brain T.	Detroit	Stern, Harry L.	Detroit
St. Amour, Hector	Detroit	Shotwell, Carlos W.	Detroit	Stern, Leonard H.	Detroit
St. Louis, R. J.	River Rouge	Shulak, Irving B.	M	Stern, Louis D.	Detroit
Sakorraphos, Stelios N.	Detroit	Shurly, Burt R.	Detroit	Stevens, Rollin H.	(E) Detroit
Salchow, Paul T.	Detroit	Sickels, Ed. W.	M	Stewart, Thomas O.	Detroit
Salowich, John N.	Allen Park	Siddall, Roger S.	Detroit	Stiefel, Daniel M.	Detroit
Saltzstein, Harry C.	Detroit	Sieber, Edward H.	Dearborn	Stirling, Alex M.	Detroit
Sander, I. W.	Detroit	Siefert, John L.	M	Stith, Dwight E.	Detroit
Sanders, Alex W.	Detroit	Siefert, Wm. A.	Detroit	Stobbe, Godfrey D.	M
Sanderson, Alvord	Grosse Pte. Pk.	Siegel, Henry	M	Stockwell, B. W.	M
Sanderson, James H.	(E) Detroit	Silverman, I. Z.	Detroit	Stofer, Bert E.	Detroit
Sanderson, Suzanne	Detroit	Silver, Israel W.	Detroit	Stokfisz, T.	M
Sandler, Nathaniel	M	Silverman, M. M.	Detroit	Stolz, Harold F.	Detroit
Sands, G. E.	Detroit	Simon, Emil R.	Detroit	Stout, Lindley H.	Detroit
Sandweiss, D. J.	Detroit	Simons, Edward J.	M	Straith, Claire L.	Detroit
Sanford, Hawley S.	M	Simpson, C. E.	Detroit	Stricker, Henry D.	Detroit
Sargent, William R.	Detroit	Simpson, H. Lee	Detroit	Strickroot, Fred L.	M
Sauk, John J.	M	Singer, Floyd W.	Detroit	Strohschein, Don F.	Detroit
Sauter, Simon H.	Detroit	Sippola, Geo. W.	Detroit	Stubbs, C. T.	Detroit
Savignac, Eugene M.	M	Sisson, John M.	Detroit	Stubbs, Harold W.	Detroit
Sawyer, Harold F.	Detroit	Siwka, Isadore J.	Detroit	Stuecheli, Milton B.	Detroit
Scarney, Herman D.	M	Skinner, Edward F.	Detroit	Sugar, David I.	Detroit
Schaefer, Robert L.	M	Skinner, W. Clare	Detroit	Sugarman, Marcus H.	M
		Skolnick, Max H.	M	Sullivan, Hugh A.	Detroit

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Summers, Wm. S.....Detroit
Surbis, John P.....Detroit
Sutherland, J. M.....Detroit
Swanson, Carl W.....Detroit
Swanson, Cleary N.....Detroit
Virgilio, Frank D.....Detroit
Switzer, Bertrand C.....Detroit
Syphax, Charles S., Jr.....Detroit
Szappanyos, Bela T.....Detroit
Szedja, J. C.....M
Szlachetka, Vincent E.....M
Szmigiel, A. J.....Detroit
Tamblyn, E. J.....Detroit
Tann, H. E.....Detroit
Tapert, Julius C.....Detroit
Tasker, Helen.....Detroit
Tassie, Ralph N.....Detroit
Tatellis, Gabriel.....Detroit
Taylor, Ivan B.....M
Taylor, Nelson M.....M
Taylor, Reu Spencer.....Detroit
Tear, Malcolm J.....M
Teitelbaum, Myer.....M
Tenaglia, Thomas A.....M
Tenerowicz, Rudolph G.....Detroit
Test, Frederick C., II.....Detroit
Texter, Elmer C.....Detroit
Thompson, Alderman.....Detroit
Thompson, David L.....Detroit
Thompson, H. E.....Detroit
Thompson, H. O.....M
Thompson, James B.....Detroit
Thompson, W. A.....Detroit
Thomson, Alexander.....Detroit
Thosteson, George C.....Detroit
Thurston, Roger G.....M
Tichenor, E. D.....Detroit
Toepel, Otto T.....(E) Detroit
Tomsu, Charles L.....Detroit
Top, E. H.....Detroit
Torrey, H. N.....Detroit
Townsend, Frank M.....Detroit
Townsend, Kyle E.....Detroit
Trask, Harry D.....Detroit
Tregenza, W. Kenneth.....Detroit
Trinity, Granville J.....Detroit
Troester, George A.....M
Trombino, James F.....Detroit
Trombley, Bryan.....Detroit
Trombley, Joseph J., Jr.....M
Troxell, Emmett C.....Detroit
Truszkowski, E. G.....M
Trythall, S. W.....Detroit
Tufford, Norman G.....Detroit
Tulloch, John.....M
Tupper, Roy D.....Detroit
Turbett, Claude W.....Detroit
Turcotte, Vincent J.....Detroit
Turkel, Henry.....Detroit
Tuttle, Wm. M.....M
Tyson, Wm. E. E.....Detroit
Ujda, Chester J.....Wayne
Ulbrich, Henry L.....Detroit
Ulch, Harold W.....Detroit
Ulrich, Willis H.....M
Umphrey, Clarence E.....Detroit
Usher, William Kay.....Detroit
Vale, C. Fremont.....Detroit
Van Auken, Edward A.....M
Van Baalen, M. R.....Detroit
Van de Velde, Honore.....Detroit
Van Gundy, Clyde R.....Detroit
Van Heldorf, Harry.....Detroit
Van Nest, A. E.....Detroit
Van Rhee, George.....Detroit
Van Riper, Steven L.....Detroit

Vardon, Colin C.....Detroit
Vardon, Edward M.....Detroit
Vasu, V. O.....Detroit
Vergosen, Harry E.....M
Vincent, James L.....Wayne
Virgilio, Frank D.....Detroit
Vogelein, Adolph E.....Detroit
Voelkner, Geo. H.....Detroit
Vogel, Hymen A.....Detroit
Vokes, Milton D.....Detroit
Von der Heide, E. C.....Detroit
Vossler, A. E.....Detroit
Vreeland, C. Emerson.....Detroit
Waddington, Joseph E. G..(E) Detroit
Wadsworth, George H.....M
Waggoner, C. Stanley.....Detroit
Waggoner, Lyle G.....Detroit
Wainger, M. J.....Detroit
Wainstock, Michael.....Detroit
Waldbott, Geo. L.....Detroit
Walker, Enos G.....M
Walker, J. Paul.....Detroit
Walker, Leo Whitney.....Detroit
Walker, Roger V.....Detroit
Walker, Sheldon A.....Detroit
Wallace, S. Willard.....Detroit
Walls, Arch.....Detroit
Walser, Howard C.....Detroit
Walsh, Charles R.....Detroit
Walsh, Francis P.....Detroit
Walters, Albert G.....Detroit
Waltz, Frank D. B.....Detroit
Waltz, Paul J.....Detroit
Ward, W. K.....Detroit
Warden, Horace F. W.....Detroit
Warner, P. L.....Detroit
Warner, Harold W.....M
Warren, Wadsworth.....M
Wasserman, Lewis C.....Detroit
Waszak, Chas. J.....Detroit
Watson, Douglas J.....M
Watson, Harwood G.....Dearborn
Watson, J. Edwin.....Detroit
Watson, Robert W.....Highland Park
Watts, Frederick B.....M
Watts, John J.....Detroit
Wayne, M. A.....Detroit
Weaver, Clarence E.....Detroit
Weaver, Delmar F.....Detroit
Webster, John E.....M
Weed, Milton R.....M
Wehenkel, Albert M.....Detroit
Weiner, M. B.....Detroit
Weingarden, David H.....Detroit
Weinstein, Jacob.....Detroit
Weisberg, A. Allen.....Detroit
Weisberg, Harry.....Detroit
Weisberg, Jacob.....M
Weisenthal, Irvin.....Detroit
Weiser, Frank A.....Detroit
Weiss, J. G.....M
Welch, John H.....Detroit
Weller, Chas. N.....Detroit
Wells, Martha.....Detroit
Weltman, Carl G.....Detroit
Wendel, Jacob S.....Detroit
Wenzel, Jacob F.....Detroit
West, Howard Gaige.....Detroit
Weston, Bernard.....Detroit
Weston, Earl E.....Detroit
Weston, Horace L.....M
Westover, Charles.....Plymouth
Weyher, Russell F.....Detroit
Whalen, Neil J.....Detroit
Wharton, Thomas V.....Wyandotte
Whinnery, Randall A.....Detroit

White, Milo R.....Detroit
White, Milton W.....Detroit
White, Prosper D., Jr.....M
White, Theodore M.....Detroit
Whitehead, L. S.....M
Whitehead, Walter K.....Detroit
Whiteley, Robert K.....M
Whitney, Elmer L.....Detroit
Whitney, Rex E.....M
Whittaker, Alfred H.....Detroit
Wiant, R. E.....Detroit
Wickham, A. B.....Detroit
Wiechowski, Henry E.....M
Wiener, I.....M
Wight, Fred B.....Detroit
Wilcox, Leslie F.....M
Wilkinson, Arthur P.....Detroit
Williams, C. J.....Detroit
Williams, Mildred C.....Detroit
Williamson, Edwin M.....M
Williamson, John G.....Dearborn
Wills, J. N.....Detroit
Willson, Wesley W.....M
Wilner, Irvin.....Detroit
Wilson, Charles Stuart.....M
Wilson, Frederic S.....Detroit
Wilson, Gerald A.....Detroit
Wilson, John D.....Detroit
Wilson, M. C.....M
Wilson, Walter J.....Detroit
Wilson, Walter J., Jr.....M
Winfield, James M.....M
Wiren, Lennart W.....Detroit
Wishrop, Edward A.....M
Wisner, Harold E.....Detroit
Wissman, H. C.....Detroit
Wittenberg, Arthur A.....Detroit
Wittenberg, Samson S.....Detroit
Wittenberg, Sydney S.....Detroit
Witter, Frank C.....Detroit
Witter, Joseph A.....M
Witus, Morris.....Detroit
Witwer, Eldwin R.....Detroit
Wolfe, Max O.....Detroit
Wollenberg, Robert A. C.....Detroit
Wood, George P.....Detroit
Wood, Kenneth A.....M
Wood, Wilford C.....Detroit
Woodry, Norman L.....Detroit
Woods, H. B.....Detroit
Woods, W. Edward.....Detroit
Woodworth, Wm. P.....Detroit
Worzniak, Joseph J.....Wyandotte
Wreggit, W. R.....M
Wruble, Joseph.....Detroit
Wunsch, Richard E.....M
Wygant, Thelma.....Detroit
York, Frederic P.....M
Yott, William J.....M
Young, Donald Andrew.....M
Young, Donald C.....M
Young, Lloyd B.....M
Young, Viola M.....Detroit
Zbudowski, A. S.....M
Zbudowski, Myron R.....M
Zemens, Joseph L.....Detroit
Zimmerman, Israel J.....M
Zimmerman, R. L.....Detroit
Zinn, Geo. H.....Detroit
Zinterhofer, John.....Detroit
Zinterhofer, Louis.....Detroit
Zlatkin, Louis.....Detroit
Zolliker, Carl R.....Detroit
Zuelzer, Wolfgang.....Detroit
Zukowski, Sigmund A.....M

Wexford County

Albi, R. W.....M
Brooks, G. W.....Tustin
Daugherty, R.....M
Hoagland, F. L.....M
Holm, Augustus.....Leroy
Holm, Benton.....Cadillac
Hoverter, J. W.....Evart

Inman, J. C.....M
Lommen, Ralph.....Manton
McCall, James H.....Lake City
McManus, Edwin.....Mesick
Masselink, H. J.....McBain
Merritt, C. E.....Manton
Mills, Robert E.....Boon
Moore, G. P.....M

Moore, Sair C.....Cadillac
Murphy, Michael R.....Cadillac
Purdy, Calvin S.....Buckley
Seltzer, Sol Norris.....Marion
Showalter, Lawrence.....M
Smith, Wallace J.....Cadillac
Tornberg, Gordon C.....Cadillac

Committee Reports

ANNUAL REPORT OF MEDICAL LEGAL COMMITTEE, 1944-45

No meeting of the Medical-Legal Committee was held during the past year as its functions are purely advisory and for review and approval of action taken in final disposition of malpractice suits instituted while the Society was obligated to furnish legal defense for its members.

During the past year one such case has been disposed of and attorneys' fees approved for payment. Correspondence has also been carried on with the Executive Secretary of the State Society in regard to other threatened suits.

In reviewing the correspondence and information furnished to the Medical Legal Committee by members of the Society who have been threatened with suits, it seems timely that the Chairman of this Committee should invite attention to certain points of importance on malpractice prophylaxis.

Extreme care in regard to records should be taken by all physicians during this period of time when inadequate and untrained clerical help is available. Every doctor should be sure that all records are complete and that the correct full name of the patient and all other data is included. If the patient receives a fracture it is essential that records show whether it was on the right or left side, and the same is true in operations, especially for hernia. If radium is inserted, the hour and the date of insertion and of removal should be recorded instead of "radium inserted at 8:30 a.m. to be removed Friday." An incomplete and inaccurate record is little better than no record at all in defense of a suit alleging negligence. It must be remembered that no practicing physician is immune to a suit, and for that reason it must be stressed that the best malpractice defense is good malpractice prophylaxis.

Respectfully submitted,
S. W. DONALDSON, M.D., *Chairman*
R. G. COOK, M.D.
R. H. DENHAM, M. D.
WM. J. STAPLETON, JR., M.D.

ANNUAL REPORT OF BEAUMONT MEMORIAL COMMITTEE, 1944-45

As stated in the report last year, the Early House on Mackinac Island has been given to the State of Michigan to be under the supervision of the Park Commission. This was made possible through the liberality of Parke-Davis and Company. I communicated with the Mackinac Island Park Commission and offered them the services of our Committee to be used in any way they saw fit if a restoration of the House is to be attempted or if they wish to build up a museum in the House. Thus far no request has come from them. Your Committee still stands ready to co-operate in every way with the Park Commission.

Respectfully submitted,
F. A. COLLIER, M.D., *Chairman*
A. W. McDONALD, M.D., *Vice Chairman*
F. C. KIDNER, M.D.
H. C. MAYNE, M.D.
LAWRENCE REYNOLDS, M.D.

ANNUAL REPORT OF THE ETHICS COMMITTEE, 1944-45

Your Ethics Committee begs to report that no new business has come to its attention since the September meeting. We regret exceedingly the very sudden and untimely death of a very able member in the person of Einer B. Andersen, M.D., of Iron Mountain. "Andy"

July, 1945

always was first in answering any correspondence, his analysis of our problems was mature, sensible and very fair and his conscientious response to his duties on the committee was reflected in his private practice which fact makes him truly a war casualty. He will receive no Purple Heart posthumously and he would want none.

Respectfully submitted,
H. W. PORTER, M.D., *Chairman*
GUY D. CULVER, M.D.
L. O. GEIB, M.D.
L. C. HARVIE, M.D.
G. B. HOOPS, M.D.
E. T. MORDEN, M.D.
LE MOYNE SNYDER, M.D.

ANNUAL REPORT OF COMMITTEE ON DISTRIBUTION OF MEDICAL CARE, 1944-45

This committee has not met during the year 1944-45.

Respectfully submitted,
R. L. NOVY, M.D., *Chairman*
R. H. BAKER, M.D.
A. F. BLIESMER, M.D.
E. I. CARR, M.D.
H. F. DIBBLE, M.D.
OTTO K. ENGELKE, M.D.
R. H. PINO, M.D.
G. B. SALTONSTALL, M.D.
WM. P. WOODWORTH, M.D.
WM. R. YOUNG, M.D.
H. B. ZEMMER, M.D.

ANNUAL REPORT OF LEGISLATIVE COMMITTEE, 1944-45

The 63rd Michigan Legislature convened on January 3 and adjourned April 27, 1945. During this period, 805 bills were introduced; sixty-four dealt directly with or touched the practice of medicine, of which twenty-nine were passed by the Legislature; an additional ten passed one house but died in the other branch; the balance either died in committee or were killed on the floor.

The 1945 Legislature enacted into law several important measures and amendments sponsored or approved by the Michigan State Medical Society. On the other hand, *no proposed legislation that would have lowered medicine's present high standards—and thereby would have been detrimental to the health and welfare of Michigan—was enacted into law in the 1945 session!*

Two State Medicine Bills

1-2. The two compulsory health insurance bills, S.B. 362 and H.B. 423, introduced towards the end of the session, were never printed and died in committee. However, the medical profession dare not be complacent as a result of this easy disposition of these unfavorable proposals, sponsored by the C.I.O. Rather, the doctors of medicine of this state must recognize the serious threat which these bills present, and must realize that only a little more than a year remains in which they can offer to the people an acceptable substitute, based on *voluntary* methods (such as Michigan Medical Service with a general broadening of its services). If Michigan's doctors of medicine do not develop their own program for more complete distribution of medical care, before the next Legislature meets in January, 1947, the medical profession may expect a bitter battle and possibly the imposition of a most objectionable program of compulsory political medicine.

Bill Proposes Medical Panel Chosen by Workmen's Compensation Commission

3. H.B. 304 represented the greatest threat to the medical profession of all the bills introduced during the past session. It provided among other things that the Workmen's Compensation Commission (a lay body) must compile, publish and supervise a panel of physicians (doctors of medicine and osteopaths); that an injured employe must choose his physician from this panel; and that no physician who is not appointed to this panel by the Commission could treat an injured workman except for first aid.

Thus the sponsors of this bill (the C.I.O.) sought to have medical practice regulated by a governmental agency composed of laymen.

This proposal was fought bitterly in both houses of the Legislature and was finally passed as a mere skeleton of its former dangerous corpulence. As enacted into law, the bill merely provided for the supplying of prosthetic appliances for compensation cases, and the inclusion of "casuals" under the Act. Signed by the Governor as Public Act No. 325 of 1945.

Other Bills Passed by the Legislature

4. S.B. 6, to permit two or more cities, etc., to maintain a community hospital—as introduced, would have authorized the hospital to practice medicine and surgery, and would have permitted others than doctors of medicine to utilize the medical facilities of such a community hospital. Amendments to eliminate these objectionable features were offered by the MSMS Legislative Committee and adopted in toto by the Senate. These eliminated any right of a hospital to practice medicine and surgery. The provision adopted by the Senate making mandatory the hospital standards recommended by the American College of Surgeons was omitted by the House, and as a result the bill went to conference committee. The final report of the conference resulted in the following terminology (in Section 6):

"The Medical Advisory Committee shall, with the approval of the hospital board, adopt rules, regulations and policies governing the professional work of the hospital and the eligibility and qualifications of its medical staff, which may conform, as nearly as practicable, to the applicable standards recommended by the American College of Surgeons."

The Governor signed the amended act, making it Public Act No. 47 of 1945.

5. H.B. 104, permitting supervisors to construct and maintain county hospitals, in counties of more than 100,000 population, for the treatment of indigent persons suffering from any physical ailment, was also amended to include American College of Surgeons standards (similar to S.B. 6), upon the recommendation of the Michigan State Medical Society. Public Act No. 109.

6. H.B. 281, provided for the creation of a state general hospital (Munson) at Traverse City. As introduced, the bill would have permitted the practice of medicine by a hospital. The MSMS offered an amendment to insure that *medical* practice in the hospital shall be on a private basis, which was adopted by the House. As passed by the Legislature, the bill fulfilled the desires of the medical profession in the area to be served by the hospital. Public Act No. 129.

7. H.B. 282, an amendment to the antenuptial physical examination act recommended by the MSMS Committee on Venereal Disease Control, successfully passed the Legislature, and was signed by the Governor as Public Act No. 230.

8. H.B. 366, permitting medical and surgical treatment of deaf children who are wards of the state, was passed by the Legislature and became Public Act No. 175.

9. H.B. 291, as introduced, would have made the Michigan Crippled Children Commission responsible for the costs of the treatment of children admitted to the neuro-psychiatric institute in Ann Arbor. This bill was

amended to satisfy the two state departments in interest, and became Public Act No. 218.

10. S.B. 295 froze the licensed status of persons in any profession or occupation, licensed by the state, until their discharge from the armed forces. Public Act No. 189.

11. H.B. 431, to create a Department of Mental Health, in lieu of the State Hospital Commission, was enacted into law and became Public Act No. 271.

12. H.B. 30, providing that information on birth and death certificates shall be typewritten or legibly printed, was passed by the Legislature and became Public Act No. 185.

13. S.B. 163 amended the barbituric act to permit refills without prescriptions, where the barbituric acid is not the principal ingredient in the preparation. The State Board of Pharmacy shall issue a semi-annual directive setting forth the barbituric acid combinations for which prescriptions may be refilled—unless otherwise designated by the prescriber. The lists shall be published in the medical and pharmaceutical journals and be mailed to every registered druggist. It is to be noted that a doctor of medicine always has the right to instruct that the prescription be not refilled. Public Act No. 123.

14. S.B. 83, the appropriation bill relating to public health, became Public Act No. 340.

15. S.B. 141, permitting the Oakland County Board of Supervisors to require the health officer to assume the duties of coroner, was passed by the Legislature and became Public Act No. 143.

16. H.B. 176, amended the act controlling tuberculosis re rules and regulations, expense of treatment, violations, reimbursements. Public Act No. 249.

17. H.B. 188, requires examination for mental or physical reasons in case of suspension or expulsion of pupil from school. The MSMS amendment to include "psychiatrists" under the act was adopted by the House. Public Act No. 70.

18. S.B. 190 contained the general amendments to the Intangible Tax Act. Public Act No. 165. (An analysis of this law will be published in an early issue of the MSMS Journal).

19. H.B. 224, authorized the State Welfare Department to operate camps for the furnishing of relief and medical care to homeless and unattached persons. Public Act No. 157.

20. H.B. 225 amends the afflicted adult act to eliminate legal settlement requirement; amends the reimbursement agreement clause; includes certain afflicted minors. Public Act No. 285.

21. H.B. 247 places the educational program of convalescent crippled children under the direction of the Supt. of Public Instruction at state expense payable to hospitals. Public Act No. 187.

22. S.B. 273 increases the hospital rates for service to crippled children "not to exceed \$7.00 per diem" for ward service. Public Act No. 227.

23. S.B. 274 increases the hospital rates for service to afflicted children "not to exceed \$7.00 per diem" for ward service. Public Act No. 228.

24. S.B. 344 provides that health officers of cities receiving a salary of \$5,000 or more shall turn over fees received for registration of births and deaths to the city treasurer. Public Act No. 312.

25. S.B. 342 raises the ceiling to \$6,000 on silicosis or other dust disease benefits under Workmen's Compensation Act. Public Act No. 318.

26-27-28. H.B. 179-180 and 181 increases state participation for indigent tubercular patients. Public Act Nos. 197-198-206.

29. H.B. 335 changes the rates and regulations for treatment of insane persons in certain public and private institutions in Wayne County. Public Act No. 235.

30. S.B. 270 increases the amount of state bounty to county health departments (\$3500 per annum for any

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1-county health district; \$5,000 for any 2-county; \$6,000 for any 3-county or 4-county health district). Public Act No. 298.

31. S.B. 223 amends the old age assistance act re residence requirements, support by others, interest in estates or trusts, hospitalization and medical care. Public Act No. 225.

32. S.B. 123, providing that all state departments shall have their rules and regulations approved by the Legislature before they become effective, passed both Houses of the Legislature, but was vetoed by the Governor. Proponents claimed that this bill was a curb on bureaucracy and on "rule by edict."

Bills Passed by Only One House

33. H.B. 20, to change the name of the State Board of Nursing, to recognize practical nurses, and to increase qualifications of registered nurses, passed the House but died in the Senate Committee.

34. H.B. 178 would have removed the limit (now 3) of the number of branch bacteriological laboratories maintained by the State Health Commissioner, passed the House but died in the Senate Public Health & Social Aid Committee.

35. H.B. 166, to permit the State Health Department to purchase and manufacture (as well as distribute) antitoxin, biological products and certain other products for use in the control of communicable diseases, was approved by the House but never left the Senate Public Health and Social Aid Committee.

36. S.B. 49, to amend the Workmen's Compensation Act by changing the number of employees subject to the Act from 8 to 2, was passed by the Senate which amended it to "6." The bill died in the House.

37. H.B. 405, a bill to provide for circuit court review from determinations made by the State Board of Registration in Medicine on revocations and suspensions of license, was passed by the House. After the Senate committee heard testimony by representatives of the State Board of Registration and of the Michigan State Medical Society, this objectionable proposal did not emerge from committee.

38. H.B. 408, to provide for medical treatment of state wards in the University of Michigan hospital, passed the House but died in the Senate Committee.

39. H.B. 419 would have made mandatory an antenatal examination to eliminate persons afflicted with epilepsy, feeble-mindedness, imbecility or insanity. Passed the House but died in the Senate Committee.

40. H.B. 388, provided for a change in the Board of Control for Vocational Education by adding two representatives of labor and two representatives of industry for 4-year terms. This Board has charge of an extensive program involving physical restoration for physically handicapped persons, including returning veterans as well as civilians. The bill passed the House but died in the Senate Committee.

41. S.B. 27 would have permitted a hospitalization fund of \$20.00 per month to those on old age assistance. This proposal was included in another bill so S.B. 27 died in a House Committee.

42. S.B. 231, general amendments to the Pharmacy Act, passed the Senate but after objectionable amendments were placed thereon in the House, the bill was recalled at the request of the pharmacists, and died in Senate Committee.

Bills That Did Not Pass Either House

43. S.B. 137 would have created a division of professional and vocational licensing in the Secretary of State's department. Civil service employees would "schedule and conduct written examinations" for 15 boards, including the Michigan State Board of Registration in Medicine. This would have made impersonal the licensing of doctors of medicine et al. Died in Senate Committee after a stormy hearing.

44. S.B. 276, a proposal similar to S.B. 137, also died in the Senate Committee.

45. S.B. 142 would have amended the Afflicted Children's Act to include children who cannot be remedied. Died in Senate Committee.

46. H.B. 182, the hospital licensing bill sponsored by the Michigan Hospital Association, was withdrawn by the M.H.A. which introduced a substitute.

47. S.B. 335, the substitute hospital licensing bill. Died in Senate Committee, after a hearing. The bill was approved by the MSMS Legislative Committee.

48. S.B. 207 provided for the construction and equipment of a new maternity hospital and children's unit at the University of Michigan hospital, to cost \$750,000. Died in Senate Committee.

49. S.B. 177 would have permitted hospital service corporations to limit reimbursement to the amount paid to the corporation by a subscriber during a 12 months' period. Died in Senate Committee.

50. H.B. 257 provided for the examination, regulation, licensing and registration of "industrial medical assistants" who were defined in the bill as persons authorized by the state to administer first aid to the sick and injured in an emergency in an industrial plant under the supervision of a licensed physician. Under this bill, the State would have recognized factory first-aiders as a profession. The bill died in the House Committee.

51. H.B. 222 would have made the state responsible for one-half the costs of the hospitalization of afflicted adults, throwing on the state an added expense of approximately \$1,750,000 per annum, based on the present low case load of afflicted adults. Died in the House Ways and Means Committee.

52. H.B. 338, requiring the enrichment of bread and flour by the addition of certain vitamins and minerals, was the subject of a public hearing but was re-referred to House Committee on Agriculture, where it died.

53. H.B. 372 would have created a department of mental health headed by a director (a psychiatrist). A substitute bill (H.B. 431 was passed by the Legislature, so H.B. 372 died in committee.

54. H.B. 409 would have required hospital service corporations to pay standard rates to hospitals. This bill was reported without recommendation by the House committee and was defeated on the floor of the House.

55. H.B. 429, to transfer the regulation of health and safety of industrial workers from the State Department of Health to the Department of Labor and Industry, died in committee.

56. H.B. 107 would have permitted the creation of psychopathic wards in municipally operated hospitals, with the state providing reimbursement for patient care. Died in House Committee.

57. H.B. 189 would have expanded special education for physically or mentally handicapped children. Died in House Committee.

58. H.B. 219 would have permitted welfare relief to non-residents when authorized in certain cases. Died in House Committee.

59. S.B. 118 provided for the licensing, inspecting, and regulating of maternity homes or hospitals. The MSMS recommended an amendment to insure that maternity homes and hospitals do not have the right to practice medicine. The bill died in the Senate Committee.

60. S.B. 145 would have repealed section in Workmen's Compensation Act providing silicosis graded death benefit. Died in Senate Committee.

61. S.B. 148 would have amended the Workmen's Compensation Act to permit unlimited medical, surgical, hospital, dental, nursing care, and prosthetic appliances until injured employee is *cured*—no time limit; also would have created free choice physician panel to be developed by Workmen's Compensation Commission (similar to H.B. 304). The confidential communication between physician and patient, in workmen's compensation

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cases, would have been destroyed. Died in Senate Committee on Labor.

62. S.B. 259 offered amendments to the Workmen's Compensation Act, increasing certain benefits, expense of examinations, etc. Died in Senate Committee on Labor.

63. S.B. 291 provided that the State Welfare Department shall pay one-half the costs of administration and of adult hospitalization. This bill was similar in intent to H.B. 222. It died in the Senate Committee.

64. S.B. 302 would have amended the Workmen's Compensation Act so that it applied to all employers regardless of number of employees; changed medical, surgical and hospital service and death benefits. Died in Senate Committee on Labor.

Thanks

The Legislative Committee again expresses appreciation to the intelligent and health-minded members of the Michigan Legislature for their courteous consideration of the legislative problems of the medical profession and the courteous reception they extended our representatives during the 1945 session.

To his Excellency, Governor Harry F. Kelly, the Legislative Committee is grateful for the friendly co-operation he and his office extended to the medical profession in all health matters.

The Committee also says sincere "thanks" to the members of the medical profession—especially the legislative keymen—who kept their friends in the Senate and House well informed concerning medical legislation.

Respectfully submitted,

H. A. MILLER, M.D., *Chairman*
C. J. BARONE, M.D.
R. G. COOK, M.D.
T. K. GRUBER, M.D.
E. D. KING, M.D.
S. L. LOUPEE, M.D.
G. L. MCCLELLAN, M.D.
HAROLD L. MORRIS, M.D.
ELMER W. SCHNOOR, M.D.
E. F. SLADEK, M.D.
R. V. WALKER, M.D.
A. VERNE WENGER, M.D.
L. G. CHRISTIAN, M.D., *Advisor*

ANNUAL REPORT OF THE COMMITTEE ON NURSES TRAINING SCHOOLS, 1944-45

The Committee did not meet this year.

All nurses training at the present time is supervised by the Army and Navy and is carried out, accordingly, at their direction. Under these circumstances, and until this arrangement is terminated, there is no work that this committee can accomplish.

Respectfully submitted,

ELLERY A. OAKES, M.D., *Chairman*
A. L. ARNOLD, JR., M.D.
C. G. CLIPPERT, M.D.
A. E. STICKLEY, M.D.
D. W. THORUP, M.D.

ANNUAL REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH, 1944-45

1. The activities of the Committee on Industrial Health were held to a minimum during the year because of travel restrictions and the time limitations of the committee members. One meeting was held, on January 17, 1945, for the primary purpose of developing a program and to make plans for the Third Annual Industrial Health Conference.

2. The Conference this year was held on April 5 at the Rackham Educational Memorial Building in Detroit in co-operation with the Department of Post-Graduate Medical Education of the University of Michigan. The meeting was attended by 164 individuals, in-

cluding physicians, nurses, personnel and employment men, and a number of plant managers.

3. A talk on industrial health, sponsored by the Committee, was presented to the Alpena County Medical Society.

4. The Chairman of the Committee attended the Regional Industrial Health Conference in Chicago on June 8 which was sponsored by the Council on Industrial Health of the American Medical Association.

Respectfully submitted,

K. E. MARKUSON, M.D., *Chairman*
H. H. GAY, M.D., *Vice Chairman*
A. L. BROOKS, M.D.
WM. P. CHESTER, M.D.
HENRY COOK, M.D.
W. A. DAWSON, M.D.
W. B. HARM, M.D.
C. K. HASLEY, M.D.
FRANK T. MCCORMICK, M.D.
C. D. SELBY, M.D.
H. T. SETHNEY, M.D.
E. C. SITES, M.D.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH—1944-1945

As indicated in item No. 4 of the original report, the chairman of the committee attended the Regional Industrial Health Conference in Chicago on June 8, which was sponsored by the Council on Industrial Health of the American Medical Association.

Considerable discussion occurred at this meeting and several items were brought out that might be used as a basis for a good program for our committee for next year. They should be especially helpful in promoting more activity on the part of local medical societies in Michigan.

Since there is such an acute shortage of physicians, every possible means must be used to provide industry with adequate medical service. To do so we must develop a better understanding of industrial medical problems between industrial physicians, private practitioners, labor and management. Much of the medical work in industry is carried on by the general practitioner and, therefore, it is important that he become familiar with plan operations, processes and harmful exposures. Management and labor should be informed in regard to the aims and merits of a proper medical program.

To disseminate such knowledge and to develop better co-operation between these groups the program of the Committee on Industrial Health for next year might include the following:

1. Continuation of the annual spring conference.
2. Arrange to hold one of the monthly meetings of the local medical societies located in industrial areas at an industrial plant having proper facilities for such a meeting. Preferably this meeting should include dinner at the plant, a tour of inspection of the plant operations, and a general talk and discussion covering the various phases of industrial medicine and its relation to private practice. Management of all local plants and labor representatives should also be invited to these meetings so that all concerned will become acquainted with the mutual problems concerning health maintenance programs.

3. The use of in-plant training programs for physicians wishing to enter industrial service.

KENNETH E. MARKUSON, M.D., *Chairman*

ANNUAL REPORT OF COMMITTEE ON PREVENTIVE MEDICINE, 1944-45

At the one meeting held by the committee during the past year the review of the activities of each of the advisory committees revealed that a great deal of essential work was accomplished in spite of the numerous

COMMITTEE REPORTS

prevailing obstacles. At least one meeting was held by each sub-committee, positive effective action characterizing practically each such event.

Of special interest and significance is the work of the Cancer Control Committee in its continuing effort to broaden the educational base for both the profession and the laity; of the Venereal Disease Control Committee in dealing with the problems of prophylaxis and in helping to modify the antenuptial examination act; of the Industrial Health Committee which this year again achieved distinction through an impressive conference on Industrial Medicine and Surgery; of the Committee on Tuberculosis Control which is involved in ironing out the difficult problems of tuberculosis case finding in industry and formulating workable plans for miniature x-ray film studies of suspects; and of both the Child Welfare and Heart and Degenerative Committees in dealing with the serious problem of rheumatic fever.

The annual reports of the individual committees which comprise the Preventive Medicine Committee are uniformly incomplete in one detail. They fail to reveal the many hours of effort which each member has generously contributed in the interest of better public health for Michigan's public.

Respectfully submitted,

WM. S. REVENO, M.D., *Chairman*
JOHN BARNWELL, M.D.
J. D. BRUCE, M.D.
B. R. CORBUS, M.D.
R. N. DEJONG, M.D.
WM. DEKLEINE, M.D.
L. O. GEIB, M.D.
WM. A. HYLAND, M.D.
H. A. LUCE, M.D.
K. E. MARKUSON, M.D.
H. H. RIECKER, M.D.
L. W. SHAFFER, M.D.
C. E. TOSHACH, M.D.
FRANK VAN SCHOICK, M.D.

ANNUAL REPORT OF THE CHILD WELFARE COMMITTEE, 1944-45

The Child Welfare Committee of the Michigan State Medical Society has had no regular meeting during the current year. Its rather limited activities have been carried on through correspondence and personal contact by the chairman with various committee members.

Contact, consultation and increasingly co-operative relations have been maintained with the chairman of the Child Welfare Committee of the American Legion. We feel this is a very important contact because in the future, even more than in the past, the Legion is going to be very active in child welfare activities. We also feel that this is the proper approach to many of our problems rather than altogether through governmental agencies.

The problem of postgraduate education and refresher courses for the returning doctor has progressed beyond the limits of our committee.

The most significant activity of our committee began nearly two years ago when we consulted frequently with Carlton Dean, M.D., of the Michigan Crippled Children Commission relative to establishing a rheumatic fever control area for a test of a proposed rheumatic fever program. In the past two years repeated contacts have been made with Dr. Dean and the program has progressed very nicely to the point where, together with the MSMS Heart and Degenerative Disease Committee, we are formulating a statewide plan for rheumatic fever control. A special committee for this study has been set up, composed of the chairmen of the Heart and Degenerative Disease Committee, the Child Welfare Committee, Carleton Dean, M.D., and L. Fernald Foster,

M.D. A résumé of this activity can best be demonstrated by the outline reproduced below.

A rheumatic fever program should concern itself with—

1. Education—lay and professional.
2. Research
3. Cases—
 - (a) case finding
 - (b) diagnosis (consultations)
 - (c) treatment (hospitalization)
 - (d) follow-up (social service, et cetera)
 - (e) schooling facilities.

Professional Education:

1. Clinic for M.D.s—invitational—intensive
2. Extramural P.G. courses
3. County Medical Society Programs
4. Necessity for reporting in Michigan

Lay Education:

1. News releases
2. Pamphlets
3. Schools (P.T.A.)
4. Public Groups (service clubs, et cetera)

Research:

This should be stimulated under private subsidization when possible.

Case Program:

1. Case finding by
 - (a) Reports of Michigan Crippled Children Commission
 - (b) Reports of Michigan Department of Health
 - (c) Physicians
 - (d) Nurses
 - (e) Others.
2. Diagnostic services—(consultations)
 - (a) Designating hospital centers where facilities and qualified personnel are available.
3. Treatment services:
 - (a) Hospitals
 - (b) Convalescent
 - (c) Boarding homes
 - (d) Home care
4. Follow-up services:
 - (a) Physicians
 - (b) Nurses
 - (c) Other trained personnel
5. Schooling:
 - (a) School authorities—state subsidy.

This program is the combined effort of the Michigan State Medical Society and the Michigan Crippled Children Commission to provide adequate facilities for the finding, treatment and prevention of rheumatic fever. It is designed to keep this activity in the hands of the practicing profession with no disturbance of the established physician-patient relationship.

Respectfully submitted,

FRANK VAN SCHOICK, M.D., *Chairman*
R. M. KEMPTON, M.D.
MOSES COOPERSTOCK, M.D.
CARLTON DEAN, M.D.
CAMPBELL HARVEY, M.D.
JOHN L. LAW, M.D.
CHAS. F. MCKHANN, M.D.
A. L. RICHARDSON, M.D.
L. PAUL SONDA, M.D.

* * *

ANNUAL REPORT OF PROFESSIONAL LIAISON COMMITTEE, 1944-45

The Committee held no meetings, as no matters or problems within the purview of the Committee's activity was referred to it during the past year.

Respectfully submitted,

ALPHEUS F. JENNINGS, M.D., *Chairman*
W. F. BOUGHNER, M.D.
R. A. SPRINGER, M.D.

Woman's Auxiliary

PRESIDENT'S MESSAGE

There will be no national convention this year. Probably there will be a Board of Directors meeting (this does *not* include state presidents). Watch *The Bulletin* for information.



We are still hoping and planning on having a state convention in September. We shall know definitely during the summer whether this will be possible. Watch *THE JOURNAL* for this news.

* * *

Have you read "The Road to Serfdom" by Frederick A. Hayek? A condensation appeared in the April *Reader's Digest*. All the

basic reasons against socialization of a group appear in this work.

* * *

I visited Jackson, Bay City and Midland, in April. On my visit to St. Clair (Port Huron) in March, the president-elect, Mrs. James M. Atkinson, turned out to be an old friend I hadn't seen in twenty years.

All the counties are doing excellent work on the state projects and are particularly interested in legislation.

Credential cards for the state convention have been sent out. Delegate cards (the portion marked "duplicate for file") should be sent to Mrs. T. Grover Amos before September 1—even if there is no convention. In this case, new officers will be voted on by mail.

MRS. H. L. FRENCH, *President*

* * *

THE COMING YEAR

Another Auxiliary year is fast drawing to a close. Each year we realize more and more that the aims of the Woman's Auxiliary have a greater importance in the scheme of things. To the members of the Woman's Auxiliary to the Michigan State Medical Society the past few years have been filled with the pressing tasks of service. In the necessity of war, we have come to know a completeness of service and a satisfaction in the knowledge that we belong to an organization which is striving to do its share in hastening the day of final victory. We are at the service of our Medical Society at all times and pledge our strength in victorious war effort and postwar planning.

Under the able guidance of our president and her efficient corps of committee chairmen, the past year has been most successful. In order that your president-elect and the new committee chairmen may make their plans for the coming year, I should like to ask that each county president for 1945-46 send me at her earliest convenience a complete list of officers and chairmen. I shall be happy to answer any questions that I can concerning auxiliary work and will welcome any suggestions our members have to offer.

Study and promote vigorously the objectives for

which we stand as an auxiliary to the Michigan State Medical Society, which are set forth in our constitution and by-laws:

(a) It is evident that Auxiliary members must know the aims of the medical profession before they can extend them to other organizations or undertake any kind of public relations work. To understand these aims requires constant reading of the national and state medical journals and also frequent attendance at Auxiliary meetings.

(b) Attend the State Medical conventions. Whether you are a delegate or not, attend all meetings. Gaining new friends is mining the richness of life.

(c) Friendliness among physicians' families cannot be too greatly emphasized at the present time when all are burdened with unusual cares and responsibilities.

(d) Is your county making an earnest effort to widen its influence in your community?

Are you promoting *Hygeia*?

Did your schools enter the Radio Speech Contest?

How many of your members subscribe to *The Bulletin*?

(e) Do you understand the provisions of the Student Loan Fund?

I wish to express my sincere thanks to our president, Lela French, and to her committee chairmen for their words of encouragement and unfailing co-operation in keeping me informed of all auxiliary activities this year. With this assistance, and with the co-operation of each and every member, we are looking forward to a year of service and achievements.

(Mrs. L. C.) DELL A. HARVIE, *President-elect*.

* * *

ORGANIZATION

This is a very difficult time for organization work. I should like to urge every Auxiliary member and county unit to consider themselves a part of my committee and grasp every opportunity to boost the organization. At this time when co-operation and unity are especially needed in the medical profession I feel that, that alone should create interest and bring all outside our Auxiliary into it. The help we have been asked to give by the State Medical Society should be sufficient proof of our worth. All this proposed legislation affecting the doctors has to be fought and information spread regarding it. The doctors themselves are much too busy and much of this falls to their wives. What thinking doctor's wife can put anything ahead of the welfare of her husband's profession?

At the present time Huron County and The Medical Society of Northern Michigan are considering organizing. Charlevoix County sent in four members-at-large and Mecosta County, one.

MRS. OSCAR D. STRYKER

State Chairman

JOUR. MSMS

*pollen
bombardment*

GONE are the days when hay fever victims piled the family into the car at the first sneeze—and headed for pollen-free areas.

This year the majority of the estimated 3,000,000 hay fever sufferers will have to "sit tight and take it" when the pollen bombardment gets under way.

Amodrine

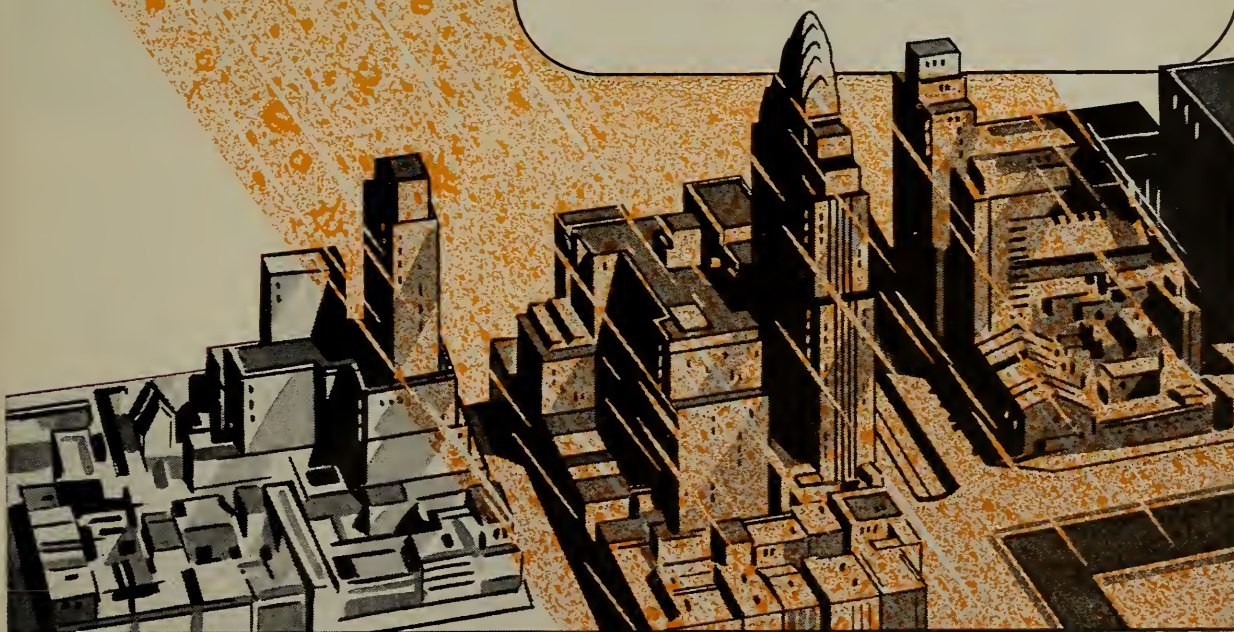
combining the sedative effect of PHENOBARBITAL 8 mg. ($\frac{1}{8}$ gr.) and the vasoconstrictor activity of RACEPHEDRINE HYDROCHLORIDE 25 mg. ($\frac{3}{8}$ gr.) with the well known antiasthmatic value of AMINOPHYLLIN-Searle 100 mgs. ($1\frac{1}{2}$ grs.)—rationally and effectively controls the symptoms of bronchial asthma and hay fever, with an absolute minimum of side reactions.

Amodrine permits your allergic patients to continue activities and obtain regular rest.

In bottles of 100 and 1000 tablets, plain or enteric coated (the latter for delayed effect).

G. D. SEARLE & CO., Chicago 80, Illinois.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

What's What

Honors

T. E. DeGurse, M.D., of Marine City, a Councilor of the Michigan State Medical Society, was recently honored upon the completion of fifty years of practice by the St. Clair County Medical Society. A distinguished company of his confrères and guests met at the St. Clair Inn on June 12 to shower Dr. DeGurse with many testimonials. Among the speakers were MSMS President A. S. Brunk, M.D., Detroit, Secretary L. Fernald Foster, M.D., Bay City, who presented a Resolution from the Michigan State Medical Society; Councilors C. E. Umphrey, M.D., Detroit, who read a Resolution from the Wayne County Medical Society; R. S. Morrish, M.D., Flint; E. R. Witwer, M.D., Detroit; O. O. Beck, M.D., Birmingham; O. D. Stryker, M.D., Fremont; MSMS Past-Presidents L. J. Hirschman, M.D., and J. M. Robb, M.D., both of Detroit.

Among others called upon by Toastmaster A. Benjamin Armsbury, M.D., of Port Huron were: E. C. Sites, M.D., and Neil J. McColl, M.D., of Pt. Huron; R. J. Hardstaff, M.D., Detroit; William J. Cassidy, M.D., Detroit; C. F. Brunk, M.D., Detroit; Major P. V. Wagley, M.D., Pontiac; R. E. Lynch, M.D., Centerline, and MSMS Executive Secretary Wm. J. Burns.

Many floral tributes and letters gave evidence of the high esteem in which Dr. DeGurse is held by the many thousands in Michigan and elsewhere who have come in contact with him during the fifty years of his medical service. He was eulogized as "the personification of the keystone in the practice of American Medicine."

The St. Clair County Medical Society presented Dr. DeGurse with a record book of the occasion, to commemorate the event.

* * *

H. W. Wiley, M.D., Utica, was honored at a testimonial dinner by the citizens of his community where he faithfully served the public for forty-six years.

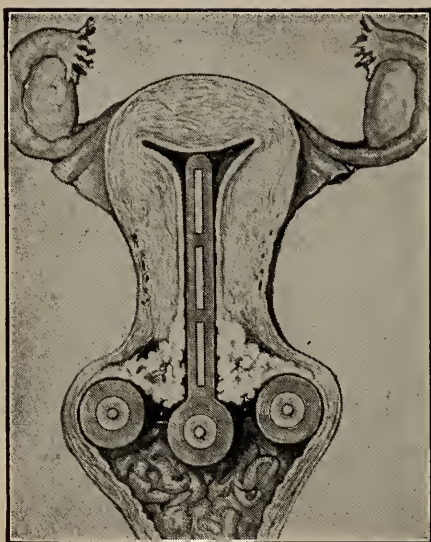
The testimonial was sponsored by the Utica Chamber of Commerce. John F. O'Hara acted as toastmaster; Clark D. Brooks, M.D., of Detroit spoke on "Dr. Wiley and His Profession."

Doctor and Mrs. Wiley were presented by the guests present with a beautiful fireplace set for their new home.

* * *

Henry R. Carstens, Colonel, MC, received an Italian decoration from the hands of Crown Prince Umberto, Lt. Gen. of the Realm, in May. He was made a Commander of the Order of the Crown of Italy. Dr.
(Continued on Page 748)

IMPROVE YOUR RESULTS IN CANCER OF THE CERVIX



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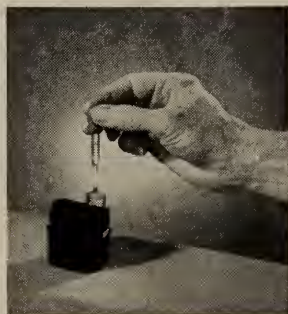
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Order from your
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(Continued from Page 746)

Carstens is a Past-President of the Michigan State Medical Society.

At the same time Col. L. Byron Ashley, MC, Lt. Col. McLester, MC, Lt. Col. C. L. Douglas, MC, and Major Steinberg, MC, were made Knights (Cavalier) of the Order of the Crown of Italy.

These awards were made for extraordinary medical service to the civilian population of Naples and vicinity.

* * *

A. S. Brunk, M.D., president of the Michigan State Medical Society, was elected permanent chairman of the Committee on Public Relations and Radio for Seventeen States at its May 24 meeting in Buffalo, N. Y. The committee represents the seventeen state medical societies which sent representatives to the Detroit Public Relations Conference, April 27. The following states were represented at the Conference: Connecticut, Delaware, Illinois, Indiana, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Wisconsin, and District of Columbia.

* * *

Wayne County Medical Society officers were hosts to Mr. Melville B. McPherson at a testimonial luncheon in the Hotel Olds, Lansing, on June 6. A certificate of Honorary Membership in the Wayne County Medical Society, conferred on Mr. McPherson at the WCMS annual meeting in May, was presented to him by immediate Past-President L. W. Hull, M.D.

* * *

Clarence L. Candler, M.D., Detroit, chairman of the MSMS Special Committee on Radio, was recently elected president of the East Side Medical Society, a branch of the Wayne County Medical Society, Detroit.

* * *

Tips

Thirty Days' Notice.—In connection with requests for Emeritus and Retired Membership, the MSMS By-Laws in Chapter I, Section 8, state: "Transfers shall be by election in the House of Delegates. Requests for transfers shall be accompanied by certification by the secretary of the State Society, as to years of practice and years of membership in good standing. The County Society of such members shall make request for certification, in writing, to the Secretary of the State Society thirty days in advance of an annual session."

* * *

A motion picture in color depicting in detail an abdominoperineal proctosigmoidectomy is available for showing by county medical societies. Write Frederick Stearns & Co., c/o John Seward, Manager of Professional Service Dept., Detroit, Michigan. The showing time of the film is thirty-eight minutes.

* * *

Schenley Laboratories, Inc., began its latest series of coast broadcasts entitled "The Doctor Fights" on June 5. These half-hour dramatizations of actual feats accomplished by medical officers of the Armed Forces during

(Continued on Page 750)



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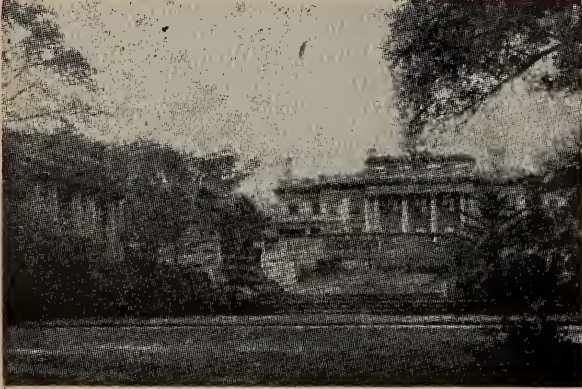
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(Continued from Page 748)

the present war will be dramatized by leading Hollywood dramatic stars.

* * *

The University of Illinois College of Medicine announces a fall refresher course in Otolaryngology, Rhinology and Otology, September 24 through 29. For further information write A. R. Hollender, M.D., 1853 West Polk Street, Chicago 12.

POSTGRADUATE CREDITS

Michigan Doctors of Medicine who have taken postgraduate courses outside the State or within the State are invited to advise H. H. Cummings, M.D., Department of Postgraduate Medicine, University Hospital, Ann Arbor, in order that proper credit may be received for Fellowship or Associate Fellowship in Postgraduate Medicine, Michigan State Medical Society.

The Annual Medicolegal Conference and Seminar of the Department of Legal Medicine of the Medical Schools of Harvard, Tufts, and Boston University in association with the Massachusetts Medicolegal Society will be held in Boston, October 1 to 6. For full information write the Secretary, 25 Shattuck Street, Boston 15.

* * *

Good Reading

Wm. S. Reveno, M.D., Detroit, is the author of an original article, "Thiouracil in Thyrotoxicosis," which appeared in JAMA, June 9.

* * *

"Spinal Anesthesia by Urethral Catheter" is the title of an original article by Major Edw. V. Tuohy, MC, AUS, Battle Creek, Michigan.

* * *

Socio-Economic

Michigan Medical Service has the largest enrollment of any voluntary medical service plan in the United States (if not the world). Its total number of subscribers amounts to some 800,000 (as of July 1). California Physician Service has the second largest enrollment of medical service plans operated in co-operation with Blue Cross; CPS totals 160,000 subscribers. In all, approximately 1,700,000 subscribers are enrolled in various medical service plans which work in conjunction with Blue Cross. In addition, several hundred thousand subscribers are enrolled in medical service plans and indemnity programs operated by medical societies, which are not associated with Blue Cross.

* * *

Fourteen compulsory health insurance measures were introduced into the Legislatures of six states in 1945; seventeen cash sickness benefit measures were proposed to the Legislatures of nine states, this year.

(Continued on Page 752)

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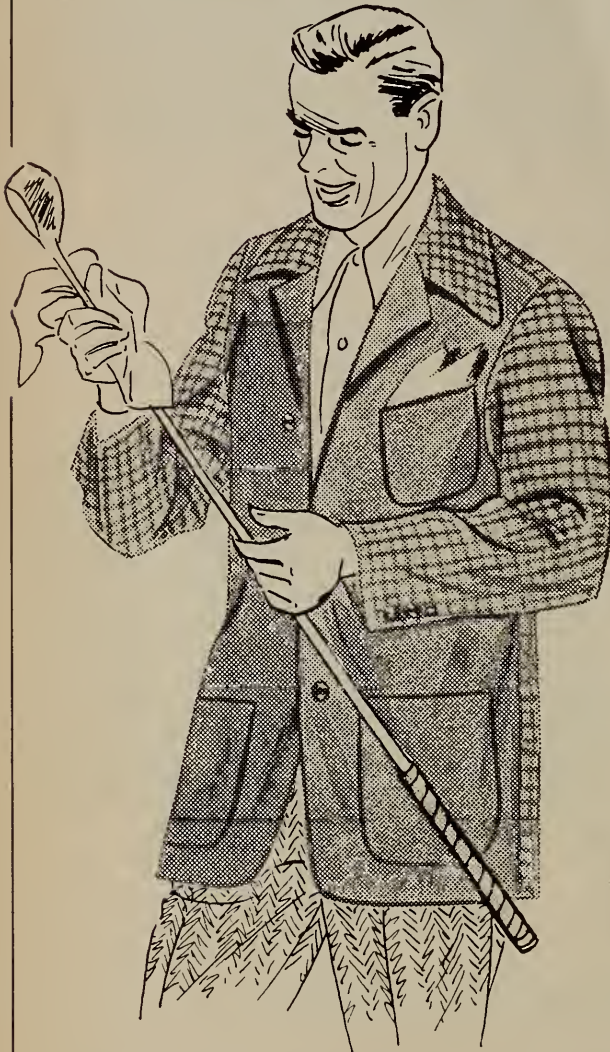
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(Continued from Page 750)

Meetings

Paul D. Bagwell of Michigan State College addressed the St. Joseph County Medical Society at the Klinger Lake Country Club on June 12. His subject was "Democracy at the Cross Roads." The meeting was attended by the druggists, dentists, lawyers, bankers and businessmen of St. Joseph county, guests of the County Medical Society.

* * *

The Southwestern Michigan Academy of Medicine was formally launched on May 11 with a dinner meeting at the Whitcomb Hotel at St. Joseph, Michigan. It was organized by leaders of St. Joseph and Benton Harbor to bring to the medical staff meetings of the twin city hospitals outstanding men in the medical profession to lecture and promote discussions on new developments and progress in the field of medical science. D. W. Thorup, M.D., of Benton Harbor, was chosen as President and R. C. Conybeare, M.D., of Benton Harbor, Secretary.

* * *

The Michigan Pathological Society held its regular bimonthly meeting at the St. Francis Hospital, Detroit, on June 9, 1945. A seminar on "Diseases of the Heart" was conducted by Dr. Otto Saphir of the Michael Reese Hospital, Chicago. Forty-four members and guests were present.

* * *

Wartime Graduate Medical Meetings held at Percy Jones General and Convalescent Hospital, Battle Creek, during June included the following: June 4, Richard H. Lyons, M.D., Ann Arbor, spoke on "Cardiovascular Dynamics"; June 11, Ralph Ghormley, M.D., Rochester, Minnesota, spoke on "Backache and Vertebral Lesions"; June 18, Major H. Chapnick and Staff spoke on "Discussion of Testicular Tumors"; Captain Mark Dale and Staff spoke on "The Post-Scrub Typhus Syndrome" and Captain W. E. Peltzer and Staff presented a case from the Percy Jones Hospital Annex; June 25, Lt. Col. Frank H. Mayfield spoke on "Statistical Report of the Work of the Neurosurgical Section since April 1, 1943; Lt. John H. Mayer spoke on "Lesions of the Posterior Interosseus Branch of the Radial Nerve; Lt. J. J. Byrne spoke on "Repair of Cranial Defects with Tantalum (Analysis of Cases Done)"; and Lt. Jack L. Ulmer spoke on "Causalgia (Analysis of seventy-five Cases)."

* * *

Talks

The MSMS commercial radio program over WJR, Fridays at 7:15 p.m., EWT, has featured the following medical speakers:

Feb. 16—C. L. Candler, M.D., Detroit, "Healthiest Nation"
Feb. 23—L. Fernald Foster, M.D., Bay City, "What MSMS Is and Does"
Mar. 2—Wm. A. Hyland, M.D., Grand Rapids, "Michigan Medical Service"
Mar. 9—O. D. Stryker, M.D., Fremont, "Medical Men in Service"

(Continued on Page 754)



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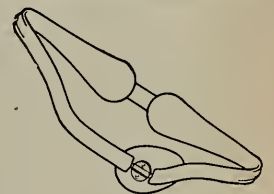
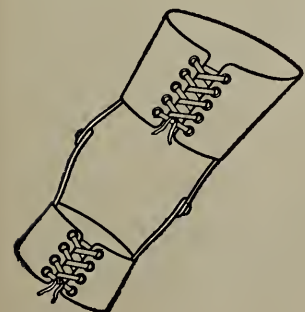
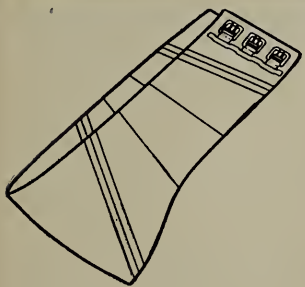
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(Continued from Page 752)

- March 16—Wilfrid Haughey, M.D., Battle Creek, "Psychiatry After the War"
Mar. 23—E. F. Sladek, M.D., Traverse City, "Voluntary Programs of Medical Care"
Mar. 30—R. S. Morrish, M.D., Flint, "Health Education of the Public"
Apr. 6—P. L. Ledwidge, M.D., Detroit, "Protection Against Major Hazards of Illness"
April 20—C. E. Umphrey, M.D., Detroit, "Postgraduate Medical Education"
Apr. 27—L. J. Hirschman, M.D., Detroit, "New Benefits under Michigan's Blue Cross Plans"
May 4—A. S. Brunk, M.D., Detroit, "Greater Safety and Health for All Workers in Industry"
May 11—O. O. Beck, M.D., Birmingham, "Our Medical Veterans' Readjustment Program"
May 18—E. R. Witwer, M.D., Detroit, "Progressive Michigan Medicine"
May 25—W. E. Barstow, M.D., St. Lou's, "A Friend in Need"
June 1—Dean W. Myers, M.D., Ann Arbor, "Blue Cross Plans and Preventive Medicine"
June 8—T. E. DeGurse, M.D., Marine City, "America Needs Medical Students NOW"
June 15—S. W. Insley, M.D., Detroit, "A Medical Co-operative"
June 22—F. H. Drummond, M.D., Kawkawlin, "Michigan Medical Service Brings Peace of Mind"
June 29—Harold A. Miller, M.D., Lansing, "Relief from the Unpredictable Financial Burdens of Illness"
July 6—J. Milton Robb, M.D., Detroit, "Michigan Medical Service Covers the Family"

* * *

WESTERN MICHIGAN RADIO FORUM

Western Michigan College of Education through its Adult Education Department, conducted a radio forum Tuesday evening, May 22, on the subject: How can we extend adequate medical care to all of our people? The Panel was composed of Anson Anderson, Executive Secretary CIO Health Center, Detroit; Odin Anderson, School of Public Health, Ann Arbor; Wilfrid Haughey, M.D., Councilor and Editor of the JOURNAL, Michigan State Medical Society, and Jay C. Ketchum, Executive Director and Vice President, Michigan Medical Service.

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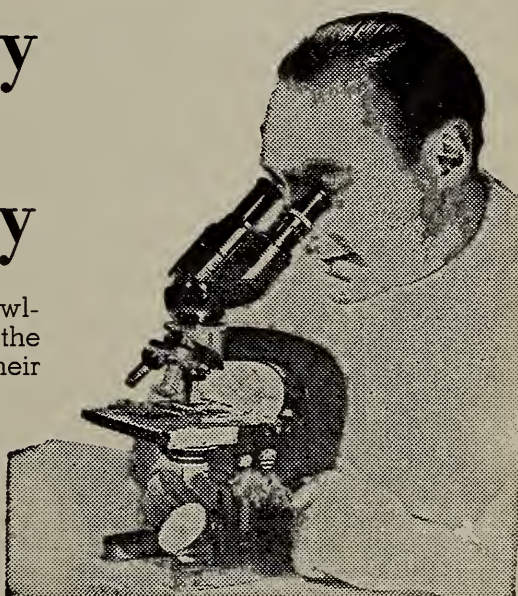
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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

MY SECOND LIFE. By Thomas Hall Shastid, A.M., M.D., LL.B., Sc.D., F.A.C.S., F.A.C.P., et cetera. Illustrated. Ann Arbor, Michigan: George Wahr, 1944. Price \$10.00. Permanent Paper Edition, \$12.00.

Doctor Shastid has already done his autobiography, but here gives intimate stories of his friends and acquaintances, making them live again. He makes distinction between a doctor's patients (sick people) and clients (those who employed him to attend their sick). The book is too thick for easy handling, but full of delightful reading.

DIETOTHERAPY—Clinical Application of Modern Nutrition: Edited by Michael G. Wohl, M.D., Associate Professor of Medicine, Temple University School of Medicine; Chairman, Advisory Committee on Nutrition, Philadelphia Department of Public Health; With a Foreword by Russell M. Wilder, M.D., Ph.D., Professor of Medicine and Chief of the Department of Medicine, Mayo Foundation; Member of the Committee on Medicine and Subcommittee on Medical Nutrition, Medical Sciences Division, National Research Council. 1029 pages with 93 illustrations. Philadelphia and London: W. B. Saunders Company, 1945. Price \$10.00.

This volume is an outgrowth of the war. The stress now in dietary treatment is not among the foods, but the food values and balances. It is actually a symposium of well-related articles by a host of authorities on medicine and nutrition. Allergies and vitamins are studied in their relations of every conceivable diseased

condition. A most interesting and valuable chapter is on nutrition, income, and budgeting. Chemistry of nutrition is given, but the tiresome tables of fat, protein and carbohydrate are in the background. Short lists of 5 per cent, 10 per cent and 15 per cent carbohydrate foods are given. Diets for cardiovascular diseases, arthritic disease, surgical cases are given. The text is a valuable guide to very exact knowledge of the whole subject of nutrition.

COURAGE AND DEVOTION BEYOND THE CALL OF DUTY. Being a partial record of official citations to medical officers in the United States Armed Forces during World War II. Preliminary Edition, November, 1944. Evansville, Indiana: Mead Johnson & Company. Free.

This little paper-covered booklet is most unusual. It lists Michigan doctors of medicine who have received citations as follows: Legion of Merit: Capt. Hermon E. Diskin, MC, U.S.A., Detroit, and Lt. Horace M. Gezon, MC, U.S.N.R.; Bronze Star: Lt. James B. Ashley, MC, U.S.A., Detroit (Posthumous), Capt. Bryne M. Daly, MC, U.S.A., Jackson (Purple Heart); Capt. Mark W. Dick, MC, U.S.A., Grand Rapids; Lt. Francis Bruce Moore, MC, U.S.A., Iron River; Silver Star: Capt. James L. Browning, MC, U.S.A., Iron Mountain; Soldier's Medal: Capt. Cecil D. Conrad, MC, U.S.A., Highland Park; Distinguished Service Cross: Capt. Harry J. Stone, MC, U.S.A., Detroit; Cited for Exceptional Devotion to Duty: Lt. Com. Cyril D. Klaus, MC, U.S.N., Grand Rapids. Commendation: Capt. Nicholas Lentini, MC, U.S.A., Cheboygan; Unit Citation, 36th General Hospital, Lt. Col. W. C. C. Cole, Commanding (Including 52 physicians).

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IT'S THE LAW, DOCTOR

(Continued from page 652)

A subsequent case arose out of an automobile accident in which an effort was made to show that the plaintiff had been feeble-minded before the accident, and that the injuries suffered were not the cause of his present mentally defective condition. The defendant persuaded the trial court that the entire file of plaintiff's hospital treatments and examinations after the crash should be admitted, pursuant to the 1935 act. The supreme court found this to be error, and said:

"This act provides for the admission of records of any act, transaction, occurrence or event if the record was made in the regular course of business and if it was the regular course of such business to make such memorandum at the time of the occurrence, or a reasonable time thereafter. *GILE v. HUDNUTT*, 279, Mich. 358 holds hospital records come within the purview of this act. However, the *GILE* case and *SADJAK v. PARKER-WOLVERINE Co.*, 281 Mich. 84, 87, both hold that the act has its limitations and that the only admissible record is that which refers to acts, transactions, occurrences or events incident to hospital treatment. Parts which do not, are hearsay and not admissible. Therefore, in admitting the hospital record, the trial court should have admitted only those parts having to do with matters within the limitations of the statute. It was error to admit parts of the hospital record which contained only information given by various people as to the history of the plaintiff prior to the accident." *VALENTI v. MAYER*, 301 Mich. 551.

The most recent case to come before our supreme court involving the question of the admissibility of hospital records, arose from the following circumstances: A woman was fatally burned as the result of an explosion of a gasoline stove. She was taken to Eloise Hospital, where she died. The records of this hospital were admitted in evidence and contained a history that the deceased had received her burns as a result of an explosion of a gasoline stove. The court held those portions of the record dealing with the history to be inadmissible, and reaffirmed its former decisions in this regard. *HARRISON v. LORENZ*, 303 Mich. 382.

In a recent malpractice case, hospital records made in regular course were offered in evidence as proof of malpractice. The defendant argued that the hospital records were privileged and that the privilege could only be waived by a living patient, but the supreme court held that the privilege might be waived by an executor or administrator and that the hospital records were admissible as evidence of malpractice. *HARVEY v. SILBER*, 300 Mich. 510.

From the foregoing discussion, it may be seen that hospital records, if made in the usual course, are now readily admissible in the courts of our state, with the principal limitation that their evidentiary value is confined to transactions, occurrences, or events which transpired at the hospital in the course of treatment.

Socialized medicine is nothing more nor less than compulsory political rationing of the nation's health services. —*The Railroad Journal*, August, 1944.

JULY, 1945

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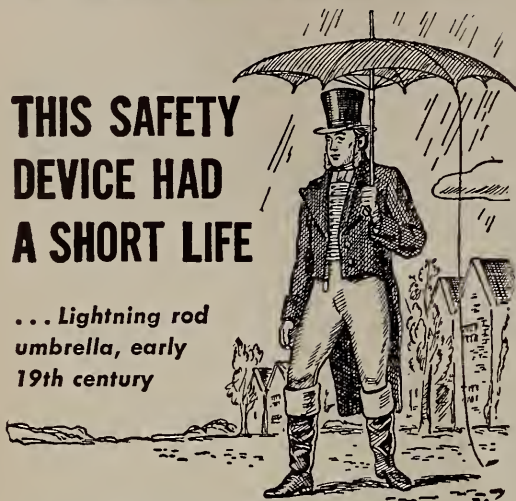
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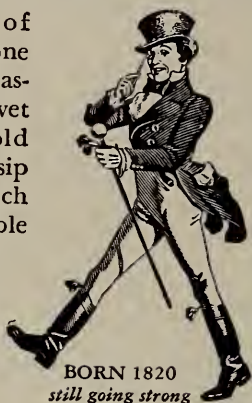
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ERTRON in Arthritis



Views of the right hand of a male, aged 42 years; illustrating typical atrophic or rheumatoid arthritis; duration of disease, 7 years; occupation, laborer.

Photographs illustrate an advanced case of atrophic (rheumatoid) arthritis showing typical spindle or fusiform shaped fingers with bluish red discolorations. The fingers show a marked subluxation involving especially the second interphalangeal joints with posterior dislocation. The characteristic flexion deformities are fixed due to fibrosis and bony ankylosis. The earlier marked soft tissue swelling has largely disappeared at this stage of the disease. General involvement: cervical spine, and bilateral involvement of the feet, ankles, knees, elbows and shoulders. X-ray of the hand reveals a destructive arthritis of the metacarpals with flexion deformity and ankylosis, loss of joint spaces particularly in the distal interphalangeal joints and partial ankylosis of the wrist joint.

County Societies

Branches of the Michigan State Medical Society

Allegan E. B. Johnson, President.....Allegan J. E. Mahan, Secretary.....Allegan	Luce R. E. Gibson, Jr., President.....Newberry Wm. R. Purmort, Jr., Secretary.....Newberry
Alpena-Alcona-Presque Isle A. Constantine, President.....Harrisville E. S. Farmer, Secretary.....Alpena	Macomb D. B. Wiley, President.....Utica C. A. Ruedisueli, Secretary.....Roseville
Barry Guy C. Keller, President.....Hastings J. K. Altland, Secretary.....Hastings	Manistee E. A. Oakes, President.....Manistee C. L. Grant, Secretary.....Manistee
Bay-Arenac-Gladwin-Iosco Thos. G. Wilson, President.....Bay City L. Fernald Foster, Secretary.....Bay City	Marquette-Alger George Keskey, President.....Marquette A. K. Bennett, Secretary.....Marquette
Berrien Frank K. Belsley, President.....Benton Harbor R. C. Conybeare, Secretary.....Benton Harbor	Mason C. C. Benjamin, President.....Ludington Chas. A. Paukstis, Secretary.....Ludington
Branch N. J. Walton, President.....Quincy James Bailey, Secretary.....Coldwater	Mecosta-Osceola-Lake B. F. Franklin, President.....Remus John A. White, Secretary.....Big Rapids
Calhoun W. O. Upson, President.....Battle Creek Francis LaFrance, Secretary.....Battle Creek	Medical Society of North Central Counties (Otsego-Montgomery-Crawford-Oscoda-Roscommon-Ogemaw) Geo. A. Drescher, President.....Lewiston Stanley A. Stealy, Secretary.....Grayling
Cass C. M. Myers, President.....Dowagiac U. M. Adams, Secretary.....Marcellus	Menominee John T. Kaye, President.....Menominee Wm. S. Jones, Secretary.....Menominee
Chippewa-Mackinac Lyman McBride, President.....Sault Ste. Marie E. S. Carr, Secretary.....Pickford	Midland C. V. High, President.....Midland Harold H. Gay, Secretary.....Midland
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You and Your Business

1945 SCIENTIFIC SESSION CANCELLED

The 80th Scientific Session of the Michigan State Medical Society, scheduled for the Book-Cadillac Hotel, Detroit, September 19-20-21, will not be held. The War Committee on Conventions has denied the request of the State Society to hold its Postgraduate Conference on War Medicine in 1945.

Plans for the 1946 Annual Session are already under way.

A skeletal session of the MSMS House of Delegates is scheduled for the Book-Cadillac Hotel, Detroit, convening at 8:00 p.m. on Monday, September 17, and continuing all day Tuesday, September 18.

CONFERENCE ON RHEUMATIC FEVER

The Council of the Michigan State Medical Society and its Committee on Rheumatic Fever Control cordially invite all members to attend a conference on rheumatic fever to be held in Detroit Wednesday and Thursday, September 19-20. Details of the program will be mailed to the membership on September 1. Several outstanding authorities on rheumatic fever will come to Michigan to highlight this two-day conference.

DENVER PUBLIC RELATIONS CONFERENCE

Michigan Medical Officers Tell Story of Progress in This State

Doctors of Medicine representing nine western states learned how the Michigan State Medical Society is combating the threat of socialized, bureaucratic political medicine by a functioning voluntary pre-payment plan and a public relations program, at a medical parley held in Denver June 28-29.

The story of how Michigan Doctors of Medicine let their world know how they supply the public with the best medical service available at a price they can pay was related to the regional meeting called by the Colorado and California Medical Associations.

Michigan speakers invited to address the conference were:

A. S. Brunk, M.D., Detroit, *President*, MSMS.

P. L. Ledwidge, M.D., Detroit, *Speaker*, House of Delegates.

E. F. Sladek, M.D., Traverse City, *Council Chairman*.

L. Fernald Foster, M.D., Bay City, *Secretary*.

C. L. Candler, M.D., Detroit, *Chairman*, Special Committee on Radio.

Wm. J. Burns, LL.B., Lansing, *Executive Secretary*.

C. H. Chapman, Chapman Agency, Detroit.

Western State Society presidents at the Public Relations Conference were: E. R. Mugrage, M.D., Denver, Colo.; Philip K. Gilman, M.D., San Anselmo, Calif.; Carl H. Gellenthien, M.D., Valmora, New Mexico; W. Andrew Bunten, M. D., Cheyenne, Wyoming; J. LaRue Robinson, M.D., Reno, Nevada; W. P. Callahan, M.D., Wichita, Kansas.

Other officers of the western state medical associations included: H. H. Skinner, M.D., Yakima, Chairman of Public Relations Committee, Washington State Medical Association; Parley Nelson, M.D., Rexburg, Past President, Idaho State Medical Association; Joseph C. Bunten, M.D., George Phelps, M.D., and Russell I. Williams, M.D., all of Cheyenne, members of Public Relations Committee, Wyoming State Medical Society; Dwight H. Murray, M.D., Napa, Legislative Chairman of the California Medical Association; George A. Unfug, M.D., Pueblo, President-Elect, Colorado State Medical Society; John S. Bouslog, M.D., Denver, Secretary, Colorado State Medical Society; Bradford Murphey, M.D., Denver, Chairman, Committee on Public Policy and George P. Lingenfelter, M.D., Denver, Past-President, Colorado State Medical Society; J. H. A. Peck, M.D., St. Francis, Kansas; B. R. Nelson, M.D., Manhattan, Kansas, Members of the Public Relations Committee of the Kansas Medical Society and Oliver Ebel, of Topeka, Executive Secretary of the Kansas Medical Society; John Hunt-on, San Francisco, Executive Secretary, California Medical Association; M. C. Smith, Lincoln, Executive Secretary, Nebraska State Medical Association; Capt. Harvey Sethman, M.A.C., Den-

(Continued on Page 780)



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DENVER PUBLIC RELATIONS CONFERENCE

(Continued from Page 778)

ver, Executive Secretary, Colorado State Medical Society; Howard Hazard, LL.B., San Francisco, Legal Counsel, and Ben Read, San Francisco, Legislative representative, California Medical Association; and William I. McNary, Denver, Director of Blue Cross and Medical Service Plans for Colorado.

The program included a discussion of "Drafting Panels" by Dr. Ledwidge and a reading of the Michigan "Outline" for necessary medical legislation by Executive Secretary Burns.

Council Chairman Sladek outlined "Progressive Activities of a State Medical Society."

President Brunk and Dr. Candler told the story of "Michigan's Experience With Commercial Radio Broadcasting"; the technical details were presented by Mr. Chapman.

"Voluntary Medical Care Programs" were outlined by Secretary Foster and resulted in an all-day discussion. The threat of socialized medicine by any plan such as the Wagner-Murray-Dingell Bill now in Congress can be shelved by giving better medical service to the people at a price they can afford to pay—and letting them know that such a pre-payment plan is available, stated Dr. Foster.

The conference, at its final session, adopted a resolution urging

1. That each state medical society formulate a statement of its position on medical care programs;

2. That each state file the name of its medical society president with the Michigan State Medical Society, which will provide a master list to all of the states, and that each state send its statement of position on medical care programs to all other state presidents prior to a conference of presidents of all the twenty-seven state medical societies represented at the Denver and the Detroit Public Relations Conferences;

3. That each state approve all methods of publicity and public information, including radio, to educate the public on the plans and aims and objectives of the medical profession.

The conference ended on a note of appreciation to the Michigan visitors for bringing helpful leadership to the western states. "Michigan has

pioneered in an unknown field," stated President-Elect Unfug of Colorado, "and we feel that we in the western states will be able to move much faster due to the preliminary work which Michigan has done for us. We are grateful to the leaders and members of that progressive State Medical Society."

SHOUT ABOUT THE GOOD WE HAVE TODAY

"Better distribution of medical care" is the war cry of social uplifters, statisticians, et cetera. Sure, better distribution is the aim of all of us, but let's pause a moment and compare medicine and its *present* distribution to other commodities.

Meat, for example, and *cigarettes*, *butter*, *metals*, *sugar*.

"Gone to War" may be the answer, especially of the government bureaucrats who have control of meat, butter, et cetera. So has the medical profession gone to war, 62,000 out of 110,000—the older and less efficient being left behind. But is there an absence—a total dearth of medical care, such as meat, butter? On the contrary, medical care is being distributed almost as well *NOW*, with fewer and older men to do it—than before the war.

Black markets plague the government planners—in their vain attempts to distribute food and other necessities according to vascillating theories hatched in Washington. No black market exists in Medicine; its humanizing affairs are in the hands of Doctors of Medicine—men of freedom, so far at least. Will government "planning" of medical service also result in a black market of this most vital necessity?

Medical service—of all the necessary services rendered the peoples of the United States—is the most widely distributed. Members of the medical profession must remember that and shout it to the treetops. This good distribution has given our people of America the best health of any people in the world.

Medical men, of course, are not satisfied with the present distribution of medical care; they never will be, as perfection is their aim in all health matters. But their programs for better distribution of medical service—such as Michigan Medical Service—are in movement and are gradu-

(Continued on Page 782)

"PREMARIN" THERAPY AT THE MENOPAUSE



"The Calm of Eventide"

It is somewhat tragic that so many women must experience a menopause that is an ordeal — thereby being deprived of the physical and mental relaxation which should come with middle age. Fortunately, estrogenic therapy can be instrumental not only in alleviating the physical distress, but also in restoring a more normal mental outlook.

The many published clinical reports on "Premarin" provide convincing evidence of its therapeutic effectiveness. Whether your patient is in the early menopause or the late climacteric, the "Calm of Eventide" is possible of attainment by means of "Premarin" therapy.

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CONJUGATED ESTROGENS (equine)

SHOUT ABOUT THE GOOD WE HAVE TODAY

(Continued from Page 780)

ally solving the problem, even as Medicine's blind critics are berating the "reactionary medical profession," screaming and writing invectives—and doing nothing else. These people, through their preachments based upon false premises, are really selling America "short," describing a picture of poverty and ill health while the United States remains far above all others the most healthy in history.

When better distribution of medical care is accomplished, it will be done by the medical profession. Doctors of Medicine are trying to improve it, constantly, in an evolutionary way. Meanwhile, let's pause to appraise the wonders of medical distribution today. Let's not belittle the good we have, just because the best lies in Utopia around the corner.

PAUL MALLON REPORTS ON THE WAGNER BILL

"A genuine basis for resistance against the Wagner-Murray-Dingell Bill exists. I suspect the administration's recalcitrance is probably due to Social Security Administrator Altmeyer's suspicion that the Wagner Bill is financially unsound. Altmeyer thinks the expenditures proposed will run far greater than the money raised by the taxes, and he has indicated that this drain on the treasury could go as high as several billions of dollars yearly.

"But the great scope of the Wagner idea raises doubt as to whether the people will get out of the bill real benefits commensurate with the terrific taxation. You never hear much about costs of these insurance panaceas. . . . Nowhere does Senator Wagner get down to the financial facts of the matter, and none of the published reports has even estimated the annual cost.

"If the federal government takes this huge amount—twice as much as it cost the whole government to operate in the Coolidge administration—and puts it in a cold fund to be doled out in dribbles to particular groups of people in particular ways, through a tremendous welfare bureaucracy, will the people generally get out of it as much as they put in? Everyone pays, few get benefits." —Paul Mallon, June 4, 1945.

"BETTER HEALTH FOR THE AMERICAN PEOPLE"

The program of the Michigan Health Council has been outlined in a brochure with the above significant title. "Better Health for the American People" endeavors to analyze the fundamental questions involved in the problem as to how the universal objective of better health care for the American people shall be achieved.

The Michigan Health Council believes that this question is not isolated, but is a part of a greater issue upon which the actual survival of democracy depends. The Council is convinced that democratic processes have lost none of their vitality or their power for both justice and progress, and that these processes are as valid in the field of health care as anywhere else.

"Better Health for the American People" is a statement concerning a most controversial current domestic issue; it shows how democratic methods can be applied to bring about better health care for the American people.

Copies of this excellent brochure are available by writing the Michigan Health Council, Washington Boulevard Building, Detroit 26, Michigan.

CALIFORNIA MEDICAL ASSOCIATION

The California Medical Association meeting held in Los Angeles, May 6 and 7, made some very important changes in the future policy of California medicine. The dues to the California Medical Association were raised from \$20 a year to \$100 a year, effective January 1, 1946. To some, this will seem to be an exorbitant increase in dues. This decision by the House of Delegates was made because we have all become more aware of the fact that we, as a profession, have been woefully weak in our public relations program. During the past several months we have been attacked by strongly organized pressure groups. The general public has been given a distorted impression of the medical profession by direct statements and by inference. The California Medical Association delegates felt that we must prepare a program to tell the people of California about the accomplishments of the medical profession and what we propose to do about aiding in the distribution of voluntary prepaid medical care. This program will necessarily be expensive, but we truly believe the profession in California will benefit immeasurably from this small investment by the individual members.—*San Francisco County M. Soc. Bull.*, 18:11, (June 19) 1945.

TABLETS FOR *Oral* USE— AMPULS FOR *Injection*

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Proceedings of Mid-Summer Session of the Council

July 13-14, 1945

Two days of discussions and joint meetings with other groups occupied the members of The Council of the Michigan State Medical Society at its Mid-Summer Session on Mackinac Island.

Following are the highlights of The Council's actions:

The Annual Report of The Council, for submission to the House of Delegates, was developed

Arrangements for a skeletal session of the MSMS House of Delegates, to be held at the Book-Cadillac Hotel, Detroit, September 17-18, were completed.

The Council adopted a statement requesting early separation of unneeded medical officers from military service and instructed that the document be sent to the Surgeons General of the



THE COUNCIL, MICHIGAN STATE MEDICAL SOCIETY AT MID-SUMMER MEETING,
JULY 13-14, 1945

FIRST ROW: E. R. WITWER, M.D., Detroit; T. E. DeGURSE, M.D., Marine City; E. F. SLADEK, M.D., *Chairman*, Traverse City; A. S. BRUNK, M.D., *President*, Detroit; A. H. MILLER, M.D., Gladstone; W. E. BARSTOW, M.D., St. Louis; L. FERNALD FOSTER, M.D., *Secretary*, Bay City.

SECOND ROW: R. S. MORRISH, M.D., Flint; O. O. BECK, M.D., *Vice Chairman*, Birmingham; WILFRID HAUGHEY, M.D., *Editor*, Battle Creek; A. B. SMITH, M.D., Grand Rapids; PHILIP A. RILEY, M.D., Jackson; O. D. STRYKER, M.D., Fremont; DEAN W. MYERS, M.D., Ann Arbor.

THIRD ROW: P. L. LEDWIDGE, M.D., *Speaker*, Detroit; W. H. HURON, M.D., Iron Mountain; R. J. HUBBELL, M.D., Kalamazoo; F. H. DRUMMOND, M.D., Kawkawlin.

Absent when picture was taken: C. E. UMPHREY, M.D., Detroit, and Wm. A. HYLAND, M.D., *Treasurer*, Grand Rapids.

and approved. This complete report of a year's activity will require some sixteen printed pages in the "Handbook for Delegates."

The semi-annual financial reports, as well as the reports of the Publication Committee, Industrial Health Committee, the Liaison Committee with the University of Michigan, Special Committee on Radio, and on the Denver Medical Public Relations Conference of June 28-29, were presented, discussed, and approved.

A conference on rheumatic fever was authorized for Detroit, September 19-20.

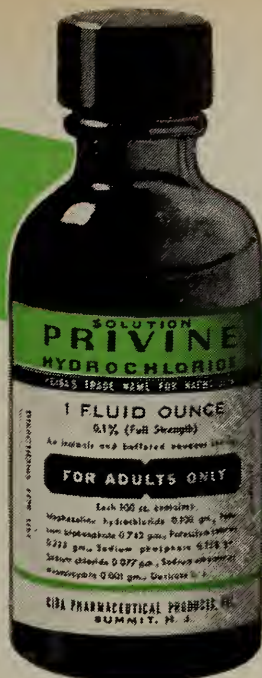
The Council made recommendations for the personnel of the Michigan State Board of Registration in Medicine, for terms expiring in 1945; these were forwarded to the Secretary of State, in accordance with Section 1 of the Medical Practice Act.

Army and Navy, the Air Surgeon, to Procurement & Assignment Service, and to Michigan members of Congress, et cetera.

A progress report on the formation of a uniform fee schedule for governmental agencies was presented by the Special Committee. It is anticipated that this uniform fee schedule will be ready for general publication about October 1.

The Council adopted a resolution requesting the House of Delegates to revoke the charter of a county medical society in Michigan.

The annual joint meeting with the members of the Michigan Crippled Children Commission, and the annual joint session with the Michigan Advisory Council of Health featured the second day of the Council's Mid-Summer Session, at which eighteen of the twenty Councilors were present.



PRIVINE IN ALLERGIC RHINITIS

Whether the *seasonal* type of allergic rhinitis is due to a sensitivity to pollens of the common trees, grasses or ragweeds, or whether the *perennial* type is caused by animal danders, vegetable powders, house dusts, foods or drugs ...PRIVINE* (Naphazoline) is extremely effective for shrinking the pale, swollen and "water-logged" nasal mucosa without compensatory swelling.

This aqueous, isotonic solution, buffered at pH 6.2 re-adjusts the alkaline secretion to normal acid range, and produces prompt and prolonged symptomatic relief for 2 to 6 hours without reapplication.

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Juris ignorantia est, cum jus nostrum ignoramus—OLD MAXIM

NOTES ON COURT DECISIONS, STATUTES AND OTHER AUTHORITIES

J. JOSEPH HERBERT, LL.B., General Counsel, MSMS

Manistique, Michigan

X-ray Pictures Taken by Physician—Whose Property—Exception to General Rule

The general rule in respect to ordinary photographs gives all the property rights in a negative to the one who employs the photographer to take the picture in the usual course of business. Is there a sufficient reason to warrant an exception in the case of x-ray negatives made by a physician, incident to the treatment of a patient? Until recently, this question had never been presented to an appellate court in this country. However, the Michigan Supreme Court was in *McGARRY vs. J. A. MERCIER COMPANY*, 272 Mich. 501, called on to give the answer. As a case of first impression it holds more than a passing interest for the medical profession.

Dr. McGarry of Fenton sued the A. J. Mercier Company for professional services rendered one of the company's employes at its request. The patient while at work had sustained a low-back injury involving the sacroiliac joint. Treatment extended over several months, during which the doctor took a number of x-ray pictures of the affected area. The company sought to avoid payment of the doctor's bill on the ground, among others, that the doctor had refused to deliver the x-ray negatives for use by other physicians. The court held that, in spite of the fact that the cost of the x-ray was charged to the patient or the one who engaged the physician, the negative was, in absence of an agreement to the contrary, the property of the physician and need not be surrendered by him.

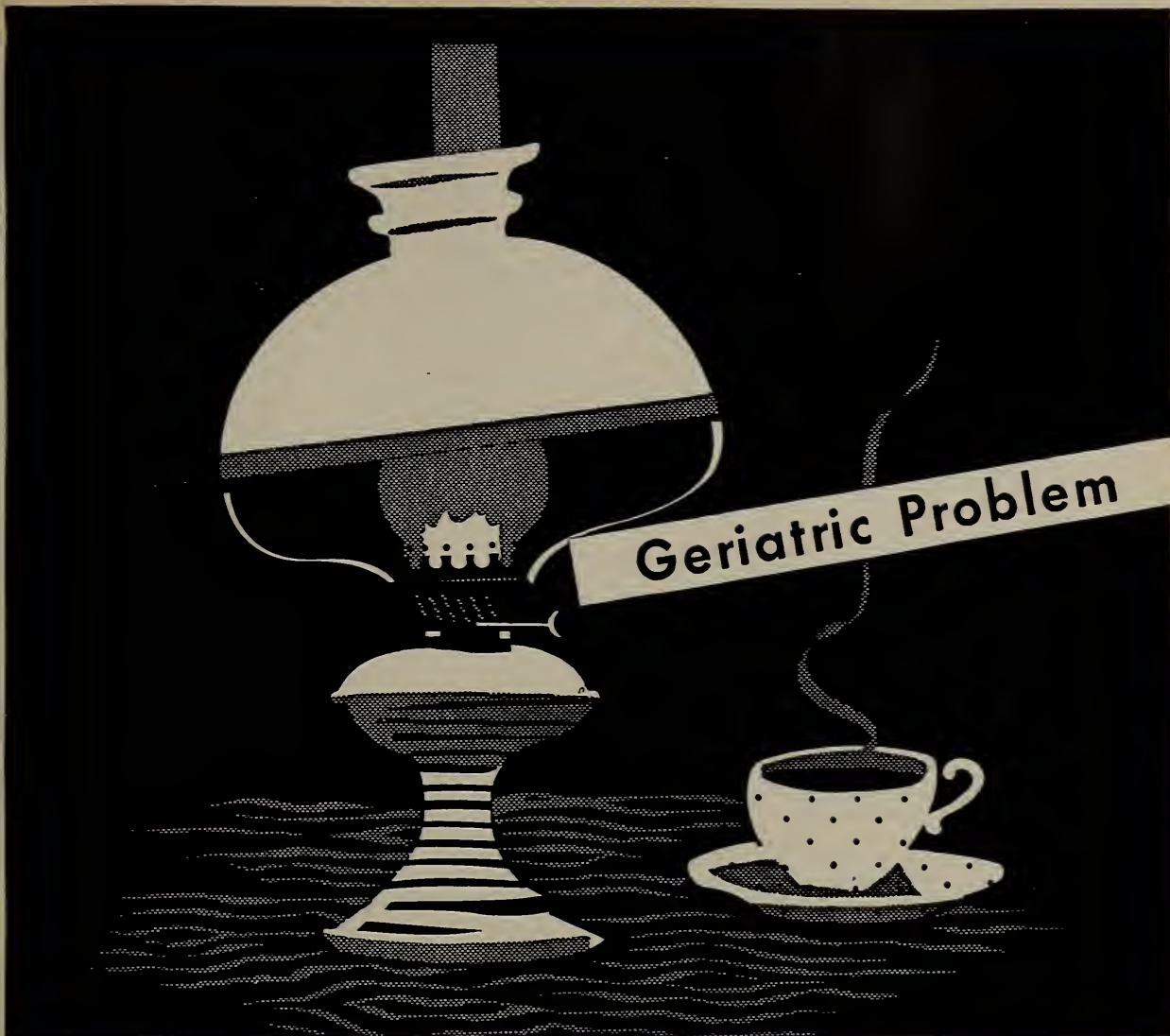
In arriving at its conclusion, the court said: "Plaintiff was fully justified in refusing to surrender possession of the x-ray negatives. In the absence of agreement to the contrary, such negatives are the property of the physician or surgeon who has made them incident to treating a patient. It is a matter of common knowledge that x-ray negatives are practically meaningless to the ordinary layman. But their retention by the physician or surgeon constitutes an important part of his clinical record in the particular case, and in the aggregate these negatives may embody and preserve much of value incident to a physician's or surgeon's experience. They are as much a part of the history of the case as any other case record made by a physician or surgeon. In a sense they differ little if at all from microscopic slides of tissue made in the

course of diagnosis or treating a patient, but it would hardly be claimed that such slides were the property of the patient. Also, in the event of a malpractice suit against a physician or surgeon, the x-ray negatives which he has caused to be taken and preserved incident to treating the patient might often constitute the unimpeachable evidence which would fully justify the treatment of which the patient was complaining. In the absence of an agreement to the contrary, there is every good reason for holding that x-ray negatives are the property of the physician or surgeon rather than of the patient or party who employed such physician or surgeon, notwithstanding the cost of taking the x-ray pictures was charged to the patient or to the one who engaged the physician or surgeon as a part of the professional service rendered." *McGARRY vs. J. A. MERCIER COMPANY*, *supra*.

WAGNER-MURRAY-DINGELL BILL

The construction of the Bill has been criticized by both its oponents and proponents and many who feel that it would not solve the medical problems of the United States. It implies that the remedy lies in passing a law which places the majority of physicians, hospitals, nurses, pharmacists, and other medical personnel under political jurisdiction. That this tremendous political responsibility should be vested in a single man (Surgeon General) with administrative powers limited only by an Advisory Council seems undemocratic. It represents an extreme viewpoint, copied from our English neighbors, who have under consideration the Beveridge Report, suggesting a lack of original thinking on our part.

The conservative and democratic solution of our medical problem is a continuation of reforms carried on by the medical profession. The physicians themselves, not government legislation, are responsible for the slow but certain evolution of superior medical schools and eradication of the diploma mills. The standardization of hospitals to higher levels of service, the critical selection of medical students with systematic training, and the creation of high standards for qualification as specialists are only a few of their accomplishments. Another milestone is voluntary hospital insurance. The next step is voluntary insurance for other types of medical service with expansion based upon experience, rather than theory and imagination of an unrepresentative minority group of social reformers.—The Dingell Bill, *Illinois M. J.*, 87:222, (May) 1945.



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AUGUST, 1945

Say you saw it in the Journal of the Michigan State Medical Society

War Medicine

GENERAL KIRK REPORTS ON MALARIA EFFECTS

Fear due to lack of information can cause more harm than malaria itself, Major General Norman T. Kirk, Surgeon General of the Army, declared in his first public report on the effects of this disease on the individual.

With the prospect of thousands of soldiers returning to this country from malarious regions, General Kirk made an appeal for a better understanding of the problem so the public will realize that, with a few simple precautions, malaria is not a disease that should give undue concern either to infected servicemen or to their families.

"The soldier who, through ignorance, worries about malaria and the chances of relapses," he said, "will suffer more ill consequences than the man who understands that with proper care this disease is not of serious import from the standpoint of the patient's general health. This very knowledge will contribute considerably to the individual's well-being and fitness."

Families should not consider soldiers infected with malaria a menace to them or the community, provided the malaria sufferer is taking treatment or promptly obtains medical care when symptoms occur.

There are a number of types of malaria, but the two that concern American troops are benign tertian malaria, which is rarely a serious disease, and malignant tertian malaria, which without treatment may be fatal. The latter type is cured by atabrine so that it is not a problem when properly treated. The attacks of malaria which soldiers will suffer after return to this country will be due to benign tertian malaria. This is the one type which is of military significance to American troops.

The serviceman infected with benign tertian malaria can continue with his usual arduous combat duties as long as he takes the necessary small doses of atabrine. Benign malaria is rarely cured by atabrine. However, this drug suppresses the disease. When a man with benign malaria stops taking atabrine, the usual symptoms—chills, fever, headache, and nausea—may appear.

In the majority of cases the disease has run its course after a man has suffered a few relapses, and no permanent damage has been done. Out of 1,000 cases, about one third will have only one attack. There will be about 40 out of 1,000 who will suffer ten relapses, and only about one in 1,000 will have as many as 20 attacks. Relapses become less acute as time goes on.

When attacks do occur, the symptoms are rapidly relieved and all progress of the disease is quickly suppressed if the proper medical care is given the patient. In most cases this can be accomplished within 48 hours.

"As a result of prompt and efficient action," he said, "attacks of malaria by themselves cause only brief incapacitation and result in no permanent damage to the body."

General Kirk stressed the point that malaria can be spread only by the anopheles mosquito. Even if a man is infected, the anopheles mosquito cannot transmit the disease unless it has bitten the victim during a relapse and before medical treatment has been secured. In most parts of the United States there is little likelihood of this since mosquito control measures are adequate.

Infected individuals who are not taking regular suppressive medication are particularly subject to relapses if they engage in strenuous work, or if they suffer from exposure, or if they indulge in drinking to excess.

One phase of malaria treatment that causes concern to many victims is the yellow color the skin takes on as a result of using atabrine. This color is not due to jaundice or any other malfunctioning of the body. It is caused directly by the yellow color of atabrine which is deposited in the skin. The yellowness will disappear a few weeks after the use of the drug is discontinued.

Deaths due to malaria since the beginning of the war have been rare. They are nearly always associated with other diseases and with circumstances which cause delayed or inadequate treatment, Army records show. In the early stages of the Pacific war, malaria did more damage to American soldiers than Jap bullets—in disabling troops, but not in killing them.

* * *

AMERICAN TYPHUS COMMISSION MEDAL AWARD

Major Chris J. Zarafonitis, MC, of Grand Rapids, Mich., was awarded the medal because "he conducted investigations in the laboratory of the American Typhus Commission at Cairo, Egypt, during 1943-1944 which have increased the knowledge of immunity following vaccination against typhus. His researches contributed to development of improved methods of treating epidemic and scrub typhus. In July, 1944, he made a survey of plague and typhus at Dakar and assisted in reducing the risk of infection of American troops. He has participated in pioneering work of control in Yugoslavia. From December, 1944, to February, 1945, he alone represented the Commission in Greece, occupying a position of great responsibility in a military mission. Under the hardships of a civil war and at risks to his personal safety he carried out surveys and, in cooperation with local authority, formulated plans and procedures for typhus control. His service in Greece was an outstanding achievement."

* * *

"SULFA" IN WOUNDS DISCONTINUED

The Army's accumulated experience in wound management does not justify the local use of any chemical agent in a wound as an anti-bacterial agent, according to the Office of the Surgeon General. The local use of crystalline sulfonamides (sulfa powder) has therefore been discontinued except in case of serous cavities where its use, while permissible under the direction of the surgeon, is not recommended. This subject is covered by War Department Circular No. 160 as amended by W. D. Circular No. 176, 1945.

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Kidney Function in Essential Hypertension

By Emil M. Isberg, M.D.
Miami Beach, Florida
and

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■ THE clinician who follows a case of hypertension must have an impression of the kidney status of his patient. Many practitioners follow this aspect of the hypertension complex merely by means of the urinalysis. We have wondered whether it could be assumed that the patient with hypertension, whose urine reveals no abnormalities, has unimpaired kidney function. At this hospital, clinical estimates of kidney function are based on the composite of three tests: (1) examination of the urine for protein, casts, and cells; (2) urea clearance test; and (3) maximal concentration test. The purpose of this study is to determine whether the latter two tests are necessary when the urine examination is negative.

Material Used

Two hundred cases were selected at random from a group whose hypertensive disease was of sufficient severity to warrant splachnicectomy. Each was studied by several examiners, and in no case could a specific cause for the hypertension be found. Their ages ranged from sixteen to fifty-eight years. The lowest blood pressure in the group was 160/90 and the highest was

290/190. None showed any evidence of congestive heart failure.

Method of Investigation

The urine examination was carried out in the routine clinical laboratory manner. Amount of protein was recorded from slight trace to 4+. The number of red and white blood cells per high power field and the number and kind of casts per low power field in the centrifuged sediment were noted. One to six urinalyses were done on each of the cases.

Urea clearance was determined by the simplified technique of Van Slyke and Cope⁸, and the values were reported in per cent of average normal. The originators of this test consider 75 to 125 per cent as normal range, 60 to 75 per cent as indicating slight impairment, 30 to 60 per cent as moderate impairment, and values below 30 per cent as marked impairment of renal function.

The concentration test used was a modification based on the principles of the Newburgh-Lashmet⁵ concentration test. It is an eighteen-hour rather than a thirty-eight-hour test. The patient finishes his usual supper by 6:00 P.M., and then he has nothing to eat or drink until the test is completed at noon the following day. Urine specimens are voided at 8:00 A.M., 10:00 A.M., and 12:00 noon, with complete emptying of the bladder. The specific gravity of each is determined, and the most concentrated specimen is tested for the presence of protein. If protein is present, its amount is quantitatively determined, and the specific gravity is corrected according to the method described by Lashmet and Newburgh.⁶ We assume a specific gravity of 1.025 or more as indicative of normal concentrating ability, 1.020 to 1.023 as slight im-

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pairment, 1.013 to 1.019 as moderate impairment, and a specific gravity below 1.013 as marked impairment. The value of 1.025 was selected as the lower limit of normal for this

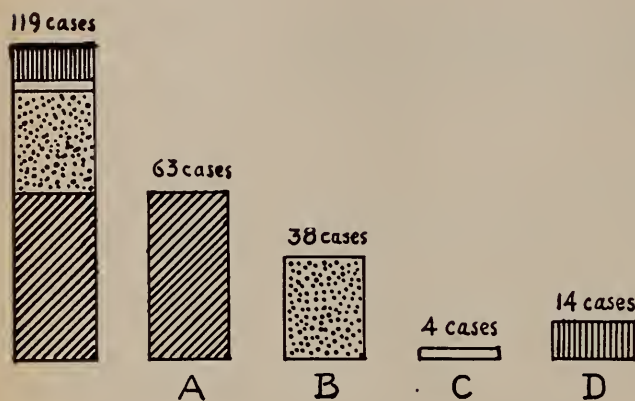


Fig. 1. Of 119 cases with normal urinalyses: (A) Sixty-three cases had normal concentration and normal urea clearance, (B) thirty-eight cases had impaired concentration but normal urea clearance, (C) four cases had impaired urea clearance but normal concentration, (D) fourteen cases had impaired concentration and impaired urea clearance.

short concentration test on the basis of results obtained from performing the test on 40 normal medical students. Thirty-seven of the normals had a maximum specific gravity of 1.025 or higher, two had a maximum concentration of 1.024, and one concentrated to 1.020.

A blood nonprotein nitrogen determination was obtained on each of the 200 patients studied, and in every case it was below 40 mgm. per cent. Thus none of the cases in this series had advanced kidney disease.

Results

1. Normal urine, normal concentration, and normal urea clearance: sixty-three cases, or 31.5 per cent of the series.

2. Abnormal concentration, but normal urine and urea clearance: thirty-eight cases, or 19 per cent of the series. Of these thirty-eight cases, twenty-one concentrated their urine between 1.020 and 1.022, sixteen concentrated between 1.013 and 1.019, and one concentrated to only 1.012.

3. Abnormal urea clearance, but normal urine and concentration: four cases, or 2 per cent of the series. One case showed slight impairment with a clearance of 67 per cent of average normal, and three cases showed moderate impairment with values between 30 per cent and 60 per cent.

4. Abnormal concentration and urea clearance, but normal urine: fourteen cases, or 7 per cent of the series. Five cases showed slight impairment of renal function with maximum specific gravities between 1.020 and 1.023 and clearance values between 60 per cent and 75 per cent. Nine cases revealed moderate impairment with specific gravities between 1.012 and 1.019 and clearance values between 30 per cent and 60 per cent.

5. Abnormal urine, but normal concentration and urea clearance: seven cases, or 3.5 per cent of the series.

6. Abnormal urine and urea clearance, but normal concentration: two cases, or 1 per cent of the series. Both cases showed slightly impaired clearance, between 60 per cent and 75 per cent.

7. Abnormal urine and concentration, but normal urea clearance: twenty-eight cases, or 14 per cent of the series.

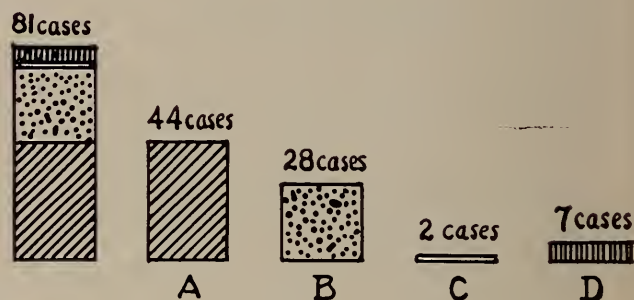


Fig. 2. Of eighty-one cases with abnormal urinalyses: (A) Forty-four cases had abnormal concentration and abnormal urea clearance, (B) twenty-eight cases had abnormal concentration but normal urea clearance, (C) two cases had abnormal urea clearance but normal concentration, (D) seven cases had normal concentration and normal urea clearance.

8. Abnormal urine, abnormal concentration, and abnormal urea clearance: forty-four cases, or 22 per cent of the series.

9. 124 cases, or 62 per cent revealed impaired concentrating ability; in eighty-one cases, or 40.5 per cent, the urine was abnormal; and sixty-four cases, or 32 per cent, demonstrated subnormal urea clearance.

Excretory pyelograms were obtained in 114 cases, and they were negative in 109. Five cases revealed minor abnormalities having no specific effect on blood pressure, such as congenital hypoplasia of one kidney, persistent dilatation of a middle calyx, and very slight hydronephrosis.

Discussion

From the foregoing results it is apparent that one cannot assume that kidney function is unim-

paired on the basis of normal urinalyses alone. In 28 per cent of the patients, renal function was impaired even though the urine revealed no abnormality upon routine examination.

The easily performed maximum-concentration test is the most sensitive of the gross tests of kidney function. Impaired concentrating ability was the sole abnormality in 19 per cent of the series, while impaired urea clearance occurred as the only abnormality in only two per cent and abnormal urinalyses occurred as the only abnormality in only 3.5 per cent. Freyberg⁴, Ellis and Weiss³, and Van Slyke⁷ have previously pointed out that the test of choice is the concentration test, that the concentrating function of the tubules is apt to show damage when the filtering function of the glomeruli does not. But it must be remembered, as Van Slyke has demonstrated, that as renal damage progresses, the urine specific gravity soon reaches a fixed, bottom level of 1.009 to 1.012, and that one must use the urea clearance test to indicate changes in the more severe degrees of kidney damage.

The results of this study corroborate Van Slyke's⁷ findings and statement that it is unnecessary to measure the urea clearance when concentrating ability is normal.

Corcoran and Page² have also shown that a decrease in maximum concentrating power occurs in most patients with hypertension months before urea clearance falls to abnormal values. They explain that this is due to intense efferent arteriolar vasoconstriction producing an increased filtration pressure which squeezes more urea through the glomeruli, and thus urea clearance may be maintained at a normal rate despite the decreased renal blood flow in the hypertensive.

We realize that the tests of the exact mechanisms involved in kidney function—such as the determinations of total effective renal blood flow, rate of glomerular filtration, maximal tubular excretory capacity, and maximal tubular reabsorptive capacity—are more accurate and will show impairment earlier than the tests used in this series. But they are time-consuming tests requiring technical assistance for their performance; at present their use is limited to special, experimental studies on patients. The clinician following a case of hypertension may safely rely on the combination of urinalysis and concentration test to render a fairly accurate picture of the patient's renal status.

Our finding of a 40.5 per cent incidence of proteinuria in 200 cases of essential hypertension is much greater than that of Brucer and Robinson.¹ They found albuminuria in 23.3 per cent of 343 hypertensive (150/90 and over) men, and in 25 per cent of 140 hypertensive women. The probable explanation of this difference is that the patients in our series had more advanced hypertensive disease. Each of our patients entered the hospital specifically for treatment of his hypertension; the elevated blood pressure was not a co-incidental finding.

Summary and Conclusion

Kidney function was studied in 200 cases of essential hypertension by means of urinalysis, maximum concentration test, and urea clearance.

Repeated negative urinalyses are not sufficient evidence to assume that kidney function is normal. In 28 per cent of the patients included in this study renal function was impaired even though the urine revealed no abnormalities upon routine examination.

The combination of normal maximum concentrating ability and normal urinalysis is a sufficient clinical indication of unimpaired renal function.

The concentration test is more sensitive than the urea clearance test in detecting early kidney damage in essential hypertension. Thirty-three per cent of the series showed impaired concentrating ability in the presence of normal urea clearance values, while in only 3 per cent was the concentrating ability adequate in the presence of subnormal urea clearance.

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Rehabilitation of the Blind

A Plan for the State of Michigan

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■ THE Federal Social Security Act of 1935 imposed upon the various states the duty of initiating and passing legislation making each state government the Federal Government's partner in the administration of social security. In such social security was included the care and, if possible, rehabilitation of the physically disabled citizens of those states. The Social Security Act includes a special provision for aid to the blind, and, in order to make this provision available to their blind citizens, most of the states shortly passed special laws bearing on that particular disability.

In Michigan, Public Law 113: Vocational Rehabilitation for the Blind is administered by the State Department of Social Welfare's Division of Services for the Blind. A significant provision newly introduced into the parent Federal law permits the states to obtain Federal funds for physical restoration of the handicapped, which is specifically differentiated from general medical care for ordinary acute illness, as well as long-term provision for chronic illness.

"Rehabilitation" thus comes to mean the treatment of static (i.e. relatively stable) conditions which competent medical authority believes can be cured entirely by proper therapy, or can be so ameliorated as to make the patient employable—in other words, an economic asset instead of a liability to his home state. The law permits hospitalization for no longer period than 90 days for any one disability. In the case of threatened blindness, however, treatment may be begun before the condition has progressed to an advanced stage, as, for example, in cases of glaucoma. This, of course, calls for competent medical opinion, which to be most effective must be sought early. Therefore, the Federal Office of

Vocational Rehabilitation has committed its physical restoration section to officers assigned for this duty from the United States Public Health Service.

Individual states such as Michigan are thus able to seek aid from this high medical authority, while at the same time the Public Health Service is obliged to work in close co-operation with those members of the medical profession in those areas, who are connected with the Federal Office of Vocational Rehabilitation. Without such active co-operation between Federal, State and local agencies a true understanding of local conditions, and of the best ways to deal with the blind, or others physically handicapped who are affected by those conditions, could hardly be reached.

The National Advisory Committee for the Office of Vocational Rehabilitation includes representatives of various medical specialties concerned with physical rehabilitation. Ophthalmologists are, therefore, actively interested in the program, and are assisted in its carrying out by the National Committee for the Industrial Placement of the Blind. Within the program there is no provision for the establishment of special hospitals or centers where only blindness is to be treated. Rather, use is to be made of facilities already existing, and the medical and surgical attention necessary will be supplied by practitioners already established in the various states, whose pre-existing hospitals will serve—in most instances—for the special needs of the blind, or otherwise physically handicapped.

As each state may have problems in regard to its blind citizens which are peculiar to itself, it may be well to examine briefly how Michigan has heretofore cared for her blind, so as to estimate the changes and additions to her previous program it will be necessary for us to undertake. Through the kindness of the State Bureau of Social Security, I was able, in 1942, to make a survey of this work accomplished up to that date, and to place this information at the disposal not only of ophthalmologists and general practitioners of medicine, but of the general public as well. I will summarize the chief findings of this survey:

The figures presented are as of March 1, 1941, and are concerned with 2,131 persons living within the boundaries of the state at that time. Not included are

those 17-year-olds or under then being cared for at the State School for the Blind, nor blind people of any age in private or public institutions. Likewise omitted were those whose impaired vision was not their chief disability who were already receiving aid from the Old Age Assistance Bureau. The criterion of blindness was that vision in the better eye was below 20/200. No one fortunate enough not to need pecuniary aid was included.

The chief causes of blindness in Michigan were shown by this survey to be infectious diseases and traumatic or chemical injuries. Syphilis, both congenital and acquired, is responsible for much destruction of vision, being 30 per cent of all cases due to infectious disease. Regarding the ocular lesions resulting from the various causal factors, optic atrophy led with 396 cases, or 18.5 per cent, followed closely by cataract with 386 cases, or 18.1 per cent.

This résumé of conditions among Michigan's blind citizens shows how we stood in the spring of 1941. The events following December 7 of that year introduced a new element into the problem of aiding our blind neighbors. When our country was plunged into war in all sections of the globe we at once faced the necessity of considering what must be done for those Michigan service people who might be returned to their home state incapacitated by partial or complete loss of vision.

The Federal program for physical restoration in all types of incapacity specifically provides means for obtaining competent medical care and all other facilities—the best available—for overcoming visual handicaps. To obtain this aid, two basic requirements must be met:

1. Medical diagnosis, embracing general medical examination, and including whatever laboratory work may be deemed necessary; together with hospital facilities when needed, must be provided in every case, to constitute a factor in the determination of eligibility.

2. When the examining physician is of the opinion that a visually handicapped person requires special diagnosis and treatment, services shall be rendered by an ophthalmologist. Supplementing these requirements is the general recommendation that everyone applying for rehabilitation because of any type of visual handicap, be referred to a qualified ophthalmologist for examination and treatment.

Under the Federal program, physical restoration will likewise be available to blind persons who have disabilities other than visual. Take,

for example, a man who has not only been blinded, but has also lost an arm or a leg. To become employable he will need an artificial limb. If he has been deafened as well as blinded, a hearing aid will be a prerequisite to rehabilitation, or a hernia operation may be needed. Those wounded on the battlefield, or in industrial explosions often stand in need of extensive plastic surgery, with artificial eyes or dental prostheses.

Quoting from an article recently published in *Hygeia*, it now appears

... that the Army will assume full responsibility for the social readjustment of the blinded personnel of both the Army and the Navy. This will be undertaken at the center ordered to be established at some point near both an Army and a Navy general hospital to which all eye patients and patients for plastic surgery will be assigned. As soon as this form of rehabilitation and all surgical care is completed, those classified as blind will be transferred to the Veterans' Administration for such vocational rehabilitation and retraining as present legislation will permit.

This will seem to take care of any blinded citizen of Michigan who could qualify for assistance from the Veterans' Administration. Though, as this article goes on to say, "It is impossible to obtain an accurate figure on the number of persons who have been reported as blinded in the war so far . . . it is the desire of the American people that those who lose their sight in the service of the country shall have the best medical and surgical care and every opportunity to be trained for normal civilian life."

The Army rehabilitation program was outlined in a paper by Brigadier General Charles C. Hillman of the U. S. Army, published in the *Journal of the American Medical Association* last June: For those whose eyes have suffered injury two hospitals have already been established, Dobbie General Hospital, Menlo Park, Calif., and Valley Forge General Hospital, Phoenixville, Pa.

Here programs of social rehabilitation are initiated and carried out simultaneously with medical and surgical treatment that may be required. To insure that blinded soldiers shall have the benefit of the most expert care at all times the War Department requires that each such casualty occurring in the United States or returned from overseas shall be reported to the Surgeon General, in whose office the case is followed until medical and surgical treatment and social rehabilitation are completed and the patient is transferred to the Veterans' Administration for vocational training.

The law specifically charges the Veterans' Administration with the vocational training of incapacitated discharged soldiers. So that those whose vision is markedly defective, or their sight entirely abolished, will become self-supporting with as little delay as possible, this training should be planned for, if not actually begun, before the blinded serviceman receives his discharge. General Hillman goes on to describe in detail what is planned for these blinded men as soon as they enter one of these special ophthalmic centers:

At the hospital designated for the care of the blind, the soldier is taught how to dress and shave, and how to feed and care for himself. He is taught to use a typewriter, as this must now be a means of communication with his friends. He is taught how to write and how to tell the time of day with a Braille watch. The Talking Book (which is a set of records to be used upon a player which is provided) opens to him the world of literature even before he learns to read Braille. Radios, which are made available, offer much enjoyment. He is taught the Braille method of reading and writing, and those who enjoy reading are encouraged to extend their study of Braille. There, teachers whose eyes have not been injured, ensure neatness of dress and good posture. Occupational therapists teach them to use their hands, to develop new perceptual skills and manual dexterity, and thus assist in restoring confidence through useful work. When the patient has learned to go about readily, he is encouraged to enlarge his social contacts, visit the city, go to concerts and get about in the world among his friends. The Red Cross makes an important contribution also in developing the family's understanding of the problems of the blind. The family is advised concerning how it may assist the patient and encourage him to develop self-reliance.

Under a plan recently developed the responsibility of the Army has been extended, in so far as the blind are concerned, beyond the time usually allotted for adequate medical and surgical treatment. "Under this plan a center will be established adjacent to one of the special Army hospitals for the blind. Here blinded service personnel of the Army, Navy, and Marine Corps will be given further training in social adjustment for an average period of four to six months. During this time aptitudes and interests will be explored and tested in pre-vocational training."

This plan, for additional time and training in social adjustment—that is, to teach men how to live in the dark—was, no doubt, first suggested by the famous St. Dunstan's center for the blind, set up in England during the first world war, and

maintained ever since. Thus when the present conflict began to take its terrible toll of ruined eyesight, the best that could be offered these unfortunates was already at their disposal. In this country, however, such a work could hardly have been carried on for that length of time on an entirely voluntary basis of support. If such a plan is to be followed here it will have to be undertaken by the Federal Government—as indeed it has been—leaving to the various states the final disposal of their own blinded citizens, when the Federal authorities have equipped them with all the educational and material assistance within reach. It would seem that Michigan is now in a position to carry on the work.

Nevertheless I feel that we should take stock of the provision heretofore made for blinded civilians, and give careful consideration to what we can do for the returned veteran. He, too, is a civilian—or soon will be once again—so his problems are much the same as those of him who never went to war. It should be borne in mind, too, that many of the cases of loss of vision which develop during army life, are not the result of wounds. Relatively few cases of visual loss, either in or outside military life, are due to traumatic injury. Systemic diseases, syphilis in particular, may long before have done serious injury to the visual apparatus, which only became apparent under the unusual strain of wartime conditions. This is apt to happen in civil as well as military life, though it might be difficult to muster any exact statistics to bear out this statement. So, we must be prepared for an increase in the number of our blind, which carries with it the implication that we must bestir ourselves to seek better means of prevention and cure.

It is not by accident that I speak of "prevention and cure" rather than "rehabilitation." Far more blindness can be cured entirely or greatly alleviated than the general public, or even the medical profession, realizes. Many an ophthalmologist still in active practice has witnessed in his professional lifetime the enactment of such measures as the protection of the eyes of the newborn, the enforcement of safety regulations in dangerous trades, and various other legal steps, all of which have succeeded in greatly lowering the incidence of blindness.

The public generally has still much to learn about the necessity for *early* examination and treatment. Traumatic injury, because it is pain-

ful and spectacular, usually gets prompt attention. The average general practitioner is aware of the dangers to vision which the "children's diseases" bring in their train—mumps, measles, and scarlet fever—so that they have inaugurated a routine to guard against them. But the more insidious conditions, the intoxications and infections which enter without any fanfare, but working silently, in the course of time bring about widespread destruction, do not get the attention their seriousness abundantly merits.

So I think any program for dealing with Michigan's blind should include "sight-saving classes" in the public schools or elsewhere, and wider enforcement of our safety laws under all working conditions which may endanger the eyesight. I think the existing state laws should be revamped by competent ophthalmologic authority to make eye examinations of the potentially blind obligatory, before their conditions are so far advanced that little can be done for them.

It is easy to say this must be done, but such enforcement presents many difficulties, especially in large centers of population where the customs and inhibitions brought from older countries still prevail. The process of examination and diagnosis now in use might very well be overhauled and brought more up to date. Even if our laws are very good they can be made still better. It should be made easier for those living far from any large medical center to get competent advice, and if it is found to be necessary, *adequate* treatment, without being obligated to give up working time to travel long distances, undergoing expense and trouble for which the more ignorant can see no warrant.

In some communities a modern version of the old-time quack "eye doctor" who traveled in a covered wagon from town to town, has appeared in the traveling eye clinic, manned by competent ophthalmologists, with specially trained nurses and social workers. Its equipment and personnel are carried in a truck fitted out for the purpose, so that it can reach the most remote settlement. At present all this has been halted by the war, but when peace comes again we may hope for its resumption. Prevention is always better than cure, and early treatment which restores the full measure of vision is infinitely superior to "rehabilitation" no matter how well accomplished. But we are facing facts, not theories. Those who

must be rehabilitated are with us *now*. It is the aim of the new Federal and State Co-operating program to extend rehabilitation services to every blind person, who can possibly be restored to employment in the various fields where their interests and capabilities can take them. It aims likewise to extend knowledge of the great capabilities of blinded workers properly trained, so that employers and the general public will have greater confidence in them, and thereby widen their opportunities to become economically useful, and socially independent. To bring this about should be the aim of all who bear at heart the best interests of Michigan's blind citizens.

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Ringworm of the Scalp Caused by *Microsporon Audouini* in Monroe County

By Hermann Pinkus, M.D.
Monroe, Michigan

■ *MICROSPORON audouini* (Gruby 1843) occupies a singular position among the fungi causing ringworm of the scalp. With the exception of *Achorion schoenleini*, the germ of favus, it is the only one which causes epidemics by contagion from person to person. Unlike favus, microsporia does not usually produce permanent baldness and scarring, but it is fully as stubborn. It is not amenable to routine antiseptic treatment, but necessitates in most cases temporary epilation of the entire scalp as a prerequisite for cure. It heals spontaneously only when the child grows up and puberty changes the reactivity of the scalp.

The first epidemic was observed in Paris by Sabouraud who rediscovered the organism and laid the foundation for diagnosis, control and treatment of microsporon ringworm fifty years ago. Later, many European cities, and New York and Chicago in this country experienced epidemics and have harbored the disease in endemic form for many years. Most epidemics were reported in large cities, or in institutions

where many children live in close contact. However, the villages of German Silesia are one example that small communities may harbor the disease. During three years spent at the University of Breslau, I had an opportunity to observe

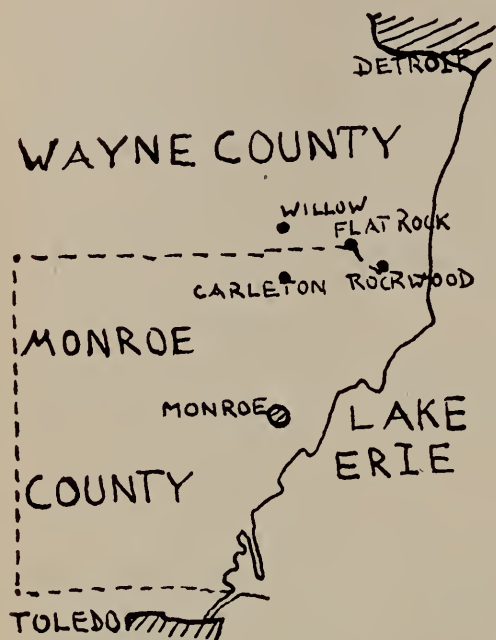


Fig. 1.

the flaring of small epidemics in one or the other of the surrounding rural communities year after year.

Michigan was fortunate in not knowing this troublesome affection until a short time ago. Now, however, we have a fairly far advanced epidemic of microsporon ringworm in some cities, and in many places a starting one. Parents, teachers, and even many physicians are slowly and painfully learning the fact that this disease is different and requires different measures for cure and control. Again, larger cities furnish the majority of cases, but small communities are not spared, and the disease may get an unnoticed foothold there where the patients are less likely seen by an experienced physician. Monroe County is rural with the exception of the city of Monroe (app. 20,000), and most of the cases so far have occurred in small villages. It may not be amiss, therefore, to give a short account of the experiences which were made in this county during the last two years.

The first two cases, negro twins living in the town of Monroe, were sent to me by the school nurse on April 1, 1942. They presented the typ-

ical "gray patch" type of ringworm. Nummular areas of short gray hair stubs without signs of inflammation were present at the back of the scalps. Microscopic examination of the roots of the broken hairs showed them full of small round spores, and a culture on Sabouraud's maltose agar produced a fungus having the characteristics of *M. audouini*. Two other siblings out of a family of eight were found infected, and another colored boy of the same neighborhood had the disease. This was considered unusual because the prevalent microsporon in this part of the country is *M. lanosum*, an organism usually transferred from animals to man, and much more amenable to treatment.

The children were referred to the University Hospital in Ann Arbor, and Dr. Udo J. Wile had the kindness of acknowledging the rarity of the disease by stating that the collection of his laboratory did not have a culture of *M. audouini* at that time. The children were epilated by means of Roentgen rays at Ann Arbor, and subsequent applications of five per cent ammoniated mercury ointment and daily shampooing with tincture of green soap completed the cure. The Monroe County Health Department was notified, and the school nurse examined the children attending the same room, but no additional cases were found.

A family of three white children was referred by their local doctor from the small village of Willow in November, 1943. They offered similar clinical and microscopic findings, and *M. audouini* was recovered in culture. Because the home of this family was in Wayne County, the health department of that county was notified and arrangements for treatment were made with their cooperation.

The next case was a white boy from Carleton who was seen in March, 1944. He had a dime-sized patch of broken hairs on the back of the scalp, and Roentgen ray epilation of an area three cm. in diameter was done. This proved insufficient. The infection spread gradually in spite of intensive local treatment. General epilation was then advised, but the case was lost track of.

In July, a white boy was brought to me by relatives with whom he was visiting in the east end of the town of Monroe. The boy's home was in Detroit, and he returned there. Two weeks later another boy of the same general neighborhood was seen with rather extensive involvement of the scalp, and was referred to Ann Arbor.

Several other cases occurred during the summer at one of the cottage colonies along Lake Erie. A family from Carleton was seen in August.

The real trouble started after school had begun. Between September 23 and November 3 twenty additional cases involving thirteen households were seen by me, and other physicians saw several more. These patients came from five distinct sources. Five children live in the east end of Monroe, three of these attend the same public school, one a parochial school, one is of preschool age. Eight patients (four families) came from Carleton, three from Flat Rock, and one from Rockwood. The last two communities are in Wayne County. Finally, three boys attend a boarding school in Monroe. One of these, according to the teacher, had the disease when he entered school last fall, coming from Detroit.

It appears then that the cases are not of uniform origin, although the fungi were identical in sixteen cases where cultures were made. In three separate instances, the disease was imported into the county from Detroit, in others the origin could not be traced. While it is likely that microsporon ringworm was brought into Michigan by wartime shifts of population, this source cannot be proven for Monroe County. All the cases were in resident families or in such visitors whose travels had no connection with the war.

In considering these cases, I wish to stress a few facts, not because they are new (they are not), but because they may be helpful in conquering the disease in this and other localities.

Clinic and Diagnosis.—The earliest noticeable lesion is a small slightly scaly spot with a few broken hairs. Inflammation, itching, or other discomfort are usually absent. Later, the typical gray patch covered with short broken hairs develops. Still later, particularly with local treatment, there may be regrowth of hair which partially hides the diseased area, but broken hairs and horny plugs in follicular openings persist. The diagnosis is confirmed by microscopic examination of diseased hairs softened in strong potassium hydroxide, and by recovery of *M. audouinii* on Sabouraud's media. In recent years, filtered ultraviolet rays (so-called black light) have become the most valuable aid in early and speedy diagnosis. Hairs infected by microsporon show a bright green fluorescence which permits to pick out single infected hairs even before they are

broken off. This is particularly valuable for quick examination of large numbers of children, and for the necessary checkup on treated cases. The method has two limitations which must be kept in mind. Other members of the microsporon family give similar fluorescence, but this is not so important under epidemic conditions. More important is the fact that even the filtered rays do not show up every infected hair. The fungi grow down into the follicular opening and invade the root of the hair first. It is only after some weeks of continued growth of the spore-filled hair that the fluorescent material appears on the surface. This is easily demonstrated by pulling out some seemingly normal hairs from the surroundings of an infected area: their roots will glow brightly in the filtered rays. It should be remembered that the diameter of an infected area is usually one or two cm. wider than the rays show, and that very early small areas do not show at all.

Localization.—The first lesions are most commonly found at the back of the head. This feature was not prominent in the German epidemics which I recall. It may be due, as has been pointed out by others, to rubbing of the head against upholstery in theaters and other public places. Infected hairs may be rubbed into the fabric and later be picked up by another occupant of the seat. Or the peculiar localization may point to the importance of infected barber tools as the electric clippers usually used on the back of the head cannot be sterilized properly.

Microsporon ringworm may affect the lanugo bearing skin of face and body. There, it forms small red circles with fine scales which sometimes glow under filtered ultraviolet rays. More often one finds a few fluorescent lanugo hairs in the center of the circle. The scales of these lesions contain an abundance of mycelia. Such lesions may occur in children with or without involvement of the scalp. I have seen them in at least two parents of affected children.

Age and Sex.—Children of all ages may be affected although the disease is most commonly encountered during the school age due to greater exposure. Microsporon ringworm usually subsides at puberty, but no definite age limit can be set. The oldest patient of my group is almost sixteen years old. Adults may be infected on the lanugo bearing skin. The number of boys

exceeds that of girls in the proportion of twenty-six to seven in my series. Two factors may be responsible. The boys may become infected in barber shops, and the long dense hair of girls may act as a natural protection preventing infectious particles from reaching the scalp.

Treatment.—Manual epilation and local antiseptics may be attempted if very small single lesions are present. Even so, the result is uncertain due to the insidious spread of the infection. Even the strongest antiseptics short of deep cauterization do not reach the growing root of the hair. The hair must be removed first. Epilation by Roentgen rays is the method of choice. It is painless. It removes all the hairs with their roots. It is safe if administered by an experienced specialist as the hair will grow back after six to eight weeks, and no permanent disfigurement will result. Most of the fungi are removed from the scalp within a period of a few days when the hair falls out fifteen to twenty days after the epilating dose was administered. The Roentgen rays affect the hair papillae in a way that they remain dormant for several weeks. During this interval, any remaining fungi have no chance of invading a growing hair. This gives us the time necessary to destroy surviving germs on the surface of the scalp by antiseptic applications. Tincture of iodine, or strong ammoniated mercury ointments in combination with daily shampoos are usually effective. Local treatment alone is usually sufficient for areas other than the scalp. Infected lanugo hairs may be pulled with forceps.

Preventive Measures.—Isolation of infected children until cure has been attained would be the most effective method. As complete isolation is not feasible the diseased children may be permitted in public, even in school, if their head is completely covered at all times by a sufficiently impervious cap. This of course is effective only if the children do not exchange caps which they are only too prone to do. Constant supervision of the younger ones and appeal to the intelligence of the older children are necessary. The wisdom of having healthy children wear caps is debatable. While it may offer some protection, the method becomes actually dangerous if the children swap caps. Moreover, it diminishes the value of the cap as a warning signal to keep at a distance from the wearer. Cleanliness at home and in public

must be stressed. Children should have their own towels, combs and brushes.

All healthy contacts, whether of school age or younger, should be examined under filtered ultraviolet rays. This examination should be repeated at least every three weeks until the epidemic has subsided. Portable lamps of suitable type are on the market at reasonable prices, and health departments or school boards should not hesitate to invest in one. Treated children should be re-examined periodically while the hair grows back so that any recurrence may be recognized while small.

Microsporon ringworm is not a reportable disease in Michigan, but should be made one unless the present epidemic is stamped out in a short time. Meanwhile the public must be educated to be watchful and co-operative. Barber shops should be warned, and their methods of sterilizing instruments checked. Most parents co-operate easily enough, not a few tend to be overanxious and must be dissuaded from taking or demanding extreme measures which would disrupt school and community life. There are, however, always parents who are either neglectful or put more faith in the good neighbor's sulphur-and-lard or gunpowder-and-vinegar recipe than in the doctor's advice. Of course, it is no small decision for a mother to sacrifice the curls of a darling daughter, even temporarily. The pressure of public opinion is the only remedy in some cases.

I close with a plea to all concerned to get together in an effort to stamp out microsporon ringworm in Michigan. We are dealing here with a disease which has been known in all its phases for many years. It can be controlled with relatively small cost and effort if it is recognized, and if measures are taken before too large an epidemic has developed. All that is necessary is to be watchful, and to apply the often proved teachings of the experience of several decades.

MSMS

ENGLAND'S BIRTH RATE INCREASES

The London correspondent of *The Journal of the American Medical Association* reports in the July 28 issue that during five years of war, England's birth rate has been rising. Last year was the highest since 1925. Not only have more babies been born but fewer have died. The chance of a baby's being born dead was only three-fourths of what it was six years ago. Also, fewer mothers were being lost in childbirth. All the vital statistics for mothers and children are the best England has ever known.

Acute Appendicitis Occurring in the Hernial Sac of a Two and One-Half Weeks Old Child

By Clifford B. Loranger, M.D.
Detroit, Michigan

■ THE finding of an appendix vermiformis in a hernial sac is rather uncommon. Appendicitis in such an anomalous condition is even more rare.

The only case similar to the one herein described that I could find in the literature was one reported by B. M. Block and J. M. Waugh. Their case was a few days younger.

A. C. Wood in a study of three thousand fifty-four cases of hernia collected from the literature reported an incidence of herniated appendices of 1.57 per cent according to the above authors. L. F. Watson collected a series of five hundred twelve cases of herniated appendices in the literature of which two hundred sixty-seven were on inguinal hernias. In this group one hundred twenty-four had symptoms of appendicitis. Considering the probable embarrassment of circulation of the appendix in this condition it is remarkable that there is not a higher incidence of inflammation. The appendix may occupy inguinal hernias more often than these studies indicate because many hernial sacs are empty when inspected, the contents having been reduced before the sac was opened.

The symptoms of herniated appendix are mild and except in acute appendicitis the diagnosis is rarely made preoperatively.

Case Report

In this case when the child was first seen it was believed that the main trouble was dietary. There was no temperature. The child was somewhat dehydrated and vomiting, even water. The abdomen was soft and tenderness could not be elicited. There was a right inguinal hernia. Twenty-four hours later the condition was the same but the right scrotal sac was becoming red and swollen.

The next day the patient was noticeably in worse condition and was hospitalized. The bowels moved but the abdomen became distended and the temperature rose to 99.4°. The scrotum became larger and more inflamed. A diagnosis of partial intestinal obstruction seemed most plausible but torsion of the testicle or orchitis could not be excluded.

The child was operated upon November 9, 1943, with a low incision extending from above the inguinal liga-

ment down on to the scrotum, under local anesthesia. The sac was isolated and found to extend into the scrotum. When opened an ounce or so of straw colored fluid escaped—a small loop of ileum was also found. It was injected and slightly dusky but definitely viable and it reduced easily. Behind this loop of bowel we encountered the appendix. It extended down into the scrotum and was adherent at its tip. When freed an acute inflammatory condition was found at the distal extremity.

The cecum could be drawn into the wound so an appendectomy was done. The sac was ligated and transfixed under the internal oblique. The hernia was repaired without transplanting the cord. Sulfathiazole crystals were placed in the wound which was closed. The wound opened on November 15, and discharged pus. The scrotum became more inflamed and fluctuation was elicited. On the 18th, 2 c.c. of fecal smelling fluid was aspirated from the scrotum—following this, recovery was uneventful. The patient was discharged from the hospital November 20.

This case is reported because it is unusual and because of the diagnostic problem presented. I wish to thank Drs. Glasgow and Jodar for their valuable consultation.

Now, approximately one year later, the child is in excellent condition and there is no recurrence of the hernia. The right testicle is very atrophic about 0.5 cm. across, the other testicle is normal.

==MSMS==

FRONT LINE PSYCHIATRY EFFECTIVE

Approximately 90 per cent of combat exhaustion cases are returned to duty largely as a result of prompt detection of symptoms and skilled handling of the patient, it was announced by the commission of outstanding civilian psychiatrists which recently completed an 11-week survey of psychiatric conditions in the European Theater of Operations.

Members of the commission expressed their "greatest admiration for the courage, ingenuity and accomplishments" of their colleagues overseas working sometimes under fire and in the face of other serious handicaps and hazards.

Combat exhaustion cases, known as shell shock in the last war, and sometimes referred to as combat fatigue or operational fatigue, are being treated more successfully in this war because of the high quality of personnel in the field and better methods and techniques. Of the greatest importance is the fact that our psychiatrists are doing some of their most effective work right up near the front at the clearing stations.

Dr. Karl Menninger, a member of the commission and director of Menninger Clinic, Topeka, Kansas, pointed out that alert and understanding sergeants and lieutenants in the front lines are anticipating cases of combat exhaustion. Symptoms are increasing irritability, lack of interest in letters from home and in comrades, and general lassitude and moroseness. A man who has reached this stage but who has not yet come to the breaking point can usually be brought back to normal by prompt evacuation to rest camps for relief from stress of battle.

CONSTRUCTIVE PROGRAM FOR MEDICAL CARE

AMERICAN MEDICAL ASSOCIATION

This platform was adopted by the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association on June 22, 1945.

Preamble

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled.

Program

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all the people:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives:

2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

3. Increased hospitalization insurance on a voluntary basis.

4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.

7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

13. Adoption of federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular army, navy and United States Public Health Service.

Fearless and United

In saying farewell as president of the Michigan State Medical Society, I look at the past to mirror the future. I see the officers, committeemen, and members of the Society working during the past twelve months as one united force to bring great tasks to fruition and to launch new endeavors. I realize how deeply indebted we all are to these laborers in the field of Medicine who have given of their valuable time, effort, and worldly goods to make their profession a better one for those who follow us. I shall always be sincerely grateful for the loyal and generous help these Men of Medicine gave me during my tenure.

The launching of new endeavors is a mark of progressive Michigan Medicine. Throughout the country, our State Medical Society has a reputation—honestly earned—as a pioneer. Others emulate our post-graduate program, our voluntary group medical care plan, our public relations project. More recent activities, such as the Medical Veterans' Readjustment Program, are being watched with interest. Our Society must continue on its course of experimentation for the benefit of the medical practitioner and the people he serves. This sailing of an uncharted and oft-perilous sea is but the penalty of leadership.

Great accomplishment marks the history of our Society, especially in recent years. This enviable past must mirror the future, particularly the immediate years ahead which carry the greatest hazards of our journey. No winds so strong or currents so swift that can harm the ship of Medicine if those on board remain fearless and work unitedly through the storm.

As Brunk

President, Michigan State Medical Society



President's



Page



Editorial

MEDICAL CARE PROGRAMS

BETTER distribution of medical care is still one of the foremost interests of the public, as indicated by the recent introduction of an augmented Wagner-Murray-Dingall Bill in Congress; by the criticism of the Veterans' Administration; by the proposals of the Children's Bureau that all maternity care should be covered by their services (Doctor Edwin F. Daily to the American Gynecological Society).

Comments in various medical Journals show that the medical world is conscious of the need to fill a demand that is increasing.

The *Nebraska State Medical Journal* says editorially (May, 1945):

"We have reached the stage where we must concentrate some of our efforts in the direction of better distribution of our services. The threat of sudden revolutionary changes imposed and controlled by political adventurers is a real challenge which can no longer be ignored. No sane physician can possibly escape the belief that the only way a deterioration of medicine can be averted is through sincere efforts toward broadening the distribution of medical service without negatively altering the quality thereof. And since the medical profession is the only group which is competent to appraise the quality of care, it obviously becomes its duty in its own behalf as well as in the interests of those whom it serves, to devise practical ways and means whereby the integrity of this important institution may survive."

The *Ohio State Medical Journal* editorially comments (June, 1945):

"Those who contend that the public wants regimented medical services haven't the proof for their conclusions. Nevertheless, the public is interested—very much so—in programs which will spread the risk and distribute the costs of medical care on a prepayment basis. The ultimate conclusion would appear that it wants the job handled through voluntary, unofficial programs under the direct guidance of the medical profession. The present attitude of the public is that it is willing to give the profession reasonable time to do the job but that it expects an early end to bickering and delay. In our opinion, the profession had better accept this challenge—and in a hurry."

Michigan has been urging for many months that action be taken leading to more complete availability and prepayment of medical services,

and a few months ago appointed a Drafting Committee to devise some plan which could be integrated with a service for all the people, a plan that the whole profession could accept and be willing to sponsor. The first plans of the Committee were published as the leading article of our June JOURNAL. Some few of our Michigan physicians have differed with the majority, honestly, in the belief that a service organization could not work, and that an indemnity plan should be formulated. Ohio as a State has chosen this course, believing that the service plan is not feasible, and has formed an Indemnity Company, the stock of which it is trying to sell to the physicians (\$105,000 capital, and \$30,000 surplus). It issues preferred stock at \$5.00 per share, and sells 1,000 shares of common stock to the State Medical Society for \$7.00 per share.

The 1945 state legislatures of six states passed enabling acts for medical plans and one for a hospital plan. Thirty-three states now have enabling acts for non-profit voluntary hospital plans, and twenty states have medical enabling acts. This shows a recognition for need in the minds of the state legislators, and an intention to allow the profession to try working out its own solution to the public demand. With such legislative action there is opportunity for the state medical societies to add their efforts to those already trying to fill an insistent urge that will, unless satisfied, lead directly to political medicine.

NEW WAGNER-MURRAY-DINGELL PROPOSALS

THE LATEST form of the Wagner-Murray-Dingell Bills was introduced in Congress on May 24, 1945, as S. 1050. This is a revamped "Cradle to the Grave" social security bill, expanded to take in many social reforms that have been advocated by social workers. It is an American version of the British Beveridge plan. The contribution rates have been changed to 4 per cent from the employer and 4 per cent from the employee. Self-employed persons contribute 5 per cent up to an income of \$3,600.

The *Globe-Democrat*, St. Louis, Mo., May 31, 1945, said:

"One of the most sinister provisions of the bill relates to the practice of medicine, which the New Dealers mask under the term 'Personal Health Service.' If carried to its logical conclusion it would destroy the medical profession as it exists today and would establish the Federal Government as the director of a national social insurance system consisting of prepaid personal health service. It would make the Federal Government the supervisor of the national health in which it would expend untold millions in the building of hospitals and health centers. . . . The government would hire doctors and establish rates of pay; establish fee schedules for services; determine the number of individuals for whom any physician may provide service; and determine arbitrarily what hospitals or clinics may provide services for patients."

When the bill was introduced Senator Wagner gave the press a release, a statement about the bills, but not the text which was available several days later. He stated "Health insurancy is *not* Socialized Medicine! it is *not* State Medicine." Ex-Senator Don H. Drukker of Passaic, N. J., in the *Herald-News*, June 9, 1945, takes issue with Senator Wagner:

"Certain doctors and dentists in each community would be designated by the Surgeon-General as the approved Federal practitioner for that area. No doctor could qualify as a specialist in any particular field save upon designation by the Surgeon-General. And no patient would be permitted to consult a specialist until the case had been "approved by a medical administrative officer appointed by the Surgeon-General."

This language, in a word, means that a patient, or a member of his family, would have to run to the Federal clinic to get permission to engage a heart or lung specialist—just as he now runs to his neighborhood ration board, hat in hand, to petition supinely for permission to buy the 20 pounds of canning sugar which, until a few days ago, might have been granted by a benevolent Government.

And all this, says Senator Wagner, is *not* Socialized Medicine, is *not* State Medicine.

Well, Senator, we have examined the text of your bill.

We think it *IS* Socialized Medicine.

We feel, further, that it is Socialized Medicine in a peculiarly obnoxious and demoralizing form.

We view it as a scheme to establish a medical bureaucracy throughout the Nation, to be dominated at length, perhaps, by a Health Master-General, just as the mails now are ruled by the Postmaster-General.

We believe that this program would lead, in due course, to an NHA, or National Health Agency, just as we now have a National Housing Authority, a WPB, OPA, WMC, OWI, and WSA.

We do not believe the American medical profession would stand still while being poured into one of these alphabetical strait jackets.

Nor do we believe the American people soon will

August, 1945

embrace a new system of ration boards, to dispense health and welfare at a flat 4 per cent rake from the weekly pay check.

If the good right ear which we keep constantly to the ground does not deceive us, *American workers already feel that too large a chunk of their weekly pay is gone before they ever get a whack at it.*

Basically, Socialized Medicine is only a new approach to another payroll "take" by those public spenders who now feel the need for new worlds to conquer in the realm of spending other people's money."

ARMY DOCTORS

Out of 110,000 effective doctors in the United States 62,000 have been commissioned in the armed forces, and have served for up to and over four years. Younger men back home have been left behind in many instances, and have then been declared essential. The position and not the doctor in many instances is what should have been declared essential. But the situation left the men already in service carrying the whole burden of fighting the war. They have done a tremendously fine job, and now many of them are hoping to be returned home.

As soon as one of these doctors reaches the United States after two or more years overseas he should be promptly returned to his home to replace some of those who had been declared essential. That would be only simple justice. They have done their part in this war. But before being returned home everyone of them should be given at least one promotion, as a reward for a fine service well done. We know many who have served two and three years without promotion. The Medical Department of the Army only stimulates disaffection by neglecting such rewards.

ON THE RUN . . .

Early civilization arose in regions where the mean temperature of the year hovers around 70° F.

• • •

A helpful sign of nervousness is to be found in the irregularity of the respiration revealed in the tracing made during a basal metabolism determination.

• • •

Gastric emptying is distinctly delayed when 500 c.c. of blood is withdrawn from the human being.

• • •

In profound jaundice a positive guaiac test is often obtained without ulceration or bleeding in the gastrointestinal tract.

• • •

It is possible to induce purulent otitis media through excessive manipulation in the ear canal.

Selected by W. S. REVENO, M.D.

Committee Reports

ANNUAL REPORT OF THE COUNCIL, 1944-45

The Council met three times and the Executive Committee met ten times (up to September 17, 1945), a total of thirteen meetings since last September's Annual Session of the State Society. All matters studied and recommendations made by the Society's twenty-eight Committees, as well as the Council's own committees, and all business of the Society were routinely referred to The Council or its Executive Committee for consideration, approval, and action.

Membership

Members of the State Society as of July 31 and as of December 31, from 1935 to 1945, are indicated in the following chart:

	1945	1944	1942	1940	1938	1935
July 31	4,425	4,615	4,553	4,401	3,958	3,410
December 31		4,702	4,714	4,527	4,205	3,653

The figures for 1945 include 3,218 active members, 56 Emeritus and Retired members, and 1,151 Military Members. Members in Military Service are accorded full membership privileges in the State Society and their dues are remitted.

Finances

The income of the Michigan State Medical Society has been further curtailed. As of July 31 there were 190 paid memberships less than of the same date in 1944. We now have 1,151 members in the armed services. In spite of this curtailment of funds, activities of the Society have been accelerated.

The ten dollar assessment for public relations has been judiciously managed, each dollar having purchased nearly two dollars' worth of services. A good example is our fortunate co-operation with the Michigan hospital superintendents, Michigan Medical Service, and Michigan Hospital Service to form the Michigan Health Council. These four organizations are banded together for the purpose of forwarding a most complete public relations program. Many pioneering projects that we were unable to consider can be executed through co-operation.

By resolution the House of Delegates levied a special assessment of five dollars for each member of the Michigan State Medical Society to procure the services of a counselor and advisor on postwar adjustments. This fund has been earmarked and segregated, and will be utilized as soon as our returning military members present the occasion to use it.

The over-all picture of cash on hand, total available cash, stocks, investments, war bonds, and foundation funds is a decidedly healthy one; this is attested to again by the Ernst & Ernst report. If he so desires, any interested member is urged to make a detailed study at the MSMS headquarters, 2020 Olds Tower, Lansing, Mich.

The Journal

During the past year several changes have been made in THE JOURNAL with a view to improving its value to the membership of the Michigan State Medical Society, and to such other readers who happen to peruse its pages. Beginning with its cover, an attempt has been made to produce an artistic effect which will be pleasing to the eye, assuming that an attractive book offers an appealing invitation to examine its contents.

The editorial policy has been a strong one, attempting to be informative and at the same time voicing the policies of organized medicine with respect to advancing trends. The medical profession of this State has definite ideas about medical economics and the distribution of medical care, and has done something concrete to supply

the medical needs of the public in the way of prepaid service. THE JOURNAL has stated these policies and has offered them as a far better system of distribution than any so far offered by nationally controlled compulsory plans.

The amount of scientific reading matter has been kept to the same total as in former years and the quality of papers presented has been good. There are many men in Michigan capable of writing excellent medical literature and in the coming year they will be encouraged to submit their work to THE JOURNAL for publication.

Considerable change has taken place in the form of advertising matter accepted for inclusion in the columns of THE JOURNAL, and many pages now appear in color. Care is taken to assure the readers that all advertising is presented by reliable manufacturers of products of recognized value, and all material submitted by them is carefully examined for approval by the Publication Committee, or by the members of the Executive Committee of The Council. By careful attention to business management the funds received from the sale of advertising space has proved sufficient to cover cost of publication.

Members of the Michigan State Medical Society in military service have always been borne in mind and THE JOURNAL has been sent to them whenever their addresses have been known.

Wilfrid Haughey, M.D., has been reappointed Editor for another year. Through his untiring efforts THE JOURNAL has maintained a consistently high grade quality. He has been fearless and just in his editorial opinions, and he crusades always for a high type of service to the public and the maintenance of proper defense of the profession against unwise legislation.

Shortage of labor and materials have caused delays in publication at times, and for the immediate future there seems to be no means of correcting this annoying factor, but it is trusted all subscribers will bear with your committee until such time as conditions are different. In the meantime, every effort will be made to continue a high standard JOURNAL, one that will justify the confidence of its readers.

County Societies

Much praise is due to all county society officers and those members who are doing their utmost day by day to further advance the cause of organized medicine. True it is that the necessities of wartime practice are making their demands upon the time and efforts of all conscientious physicians. Many who have been deserving of rest have had to assume the rigors and obligations of busy practices and have been unable to allow themselves proper opportunities for relaxation and recuperation. Many of our friends and co-workers have become casualties of war time by giving their all to the point of exhaustion and have made the supreme sacrifice in so doing. But such is the price that must be paid if we are to continue to prove that the time-honored practice of medicine in our American way must continue. It is the duty of all our members to keep before the American people the adequacy of our medical care and thus demonstrate the falsity of the teachings of those who would take advantage of the present emergency to force upon this country some foreign type of Federalized Medicine.

In spite of the wartime difficulties which have caused limitations in the scope of some of the county society programs, still the various local societies on the whole have been able to conduct their meetings as well and have had as good meetings as at any time prior to the entrance of our country into war. It is very gratifying to note that in many cases programs have been given by the members of the local societies with most happy re-

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sults, inasmuch as not only the society benefited from the papers given but members who have taken part in the programs have also gained by the preparation of such papers and reports. A few of our larger and active societies have held successful one day clinics. These clinics have been well attended and the speakers and the material presented have been most excellent.

We have been glad to welcome back to civilian practice a few of our military members who have been given their release from military service. We all appreciate the great sacrifice made by these men in leaving their established practices and their homes in order to better serve their country in its struggle with a strong and vicious enemy. It is the duty of each county society to do all in its power in enabling these returned members again to take up their life from which they became dislocated and we are sure that all county societies in our state are anxious to do so. Your Council has spent the past year in studying the various plans for the rehabilitation of these men and has developed a definite program which will do much to enable the veteran to re-establish himself.

Organization

F. H. Drummond, M.D., of Kawkawlin was appointed Councilor of the Tenth District during the past year to fill the vacancy caused by the resignation of *R. C. Perkins, M.D.*, Bay City.

Organization in all component county medical societies, except one, continues to be good despite the restrictions of wartime travel, et cetera.

The County Secretaries' Conference of January 28, 1945, at the Book-Cadillac Hotel, Detroit, was another "School of Information." A large and interested group heard the presentation of topics important to Medicine by *W. W. Bauer, M.D.*, Chicago, *Paul D. Bagwell*, East Lansing, *John F. Hunt*, Chicago, *Joseph S. Lawrence, M.D.*, Washington, D. C., *Edward F. Stegen*, Chicago, and *E. F. Sladek, M.D.*, Traverse City.

Eight Secretary's Letters were mailed during the year, three to all members of the Society and five to Presidents, Secretaries and Editors of County Medical Societies. In addition, 14 Legislative Bulletins were mailed from the MSMS Executive Office.

AMA Delegates—the usual meeting of the Executive Committee with Michigan Delegates to the AMA House of Delegates was held in June. A number of important economic and sociologic matters, which undoubtedly will be considered at the next meeting of the AMA, were discussed.

Detroit Public Relations Conference of April 27-28. This outstanding achievement in medical organization work is detailed in the Annual Report of the Special Committee on Radio, which initiated the idea to bring the executives of 16 eastern and mid-western state medical societies to Detroit to see the work of Michigan Medical Service, and to co-operate in plans for necessary medical legislation, and for better public relations through the use of the press and radio.

The Denver Public Relations Conference of June 28-29 was a replica, for 10 western states, of the Detroit meeting. As in April, the program of the June Conference was presented by MSMS officers by invitation.

Committees

Despite wartime restrictions on travel and demands on the time of MSMS committee members, most of the State Society committees continue to be very active. The outstanding progress and leadership of the Michigan State Medical Society is reflected in the work of our very active committees. We earnestly invite your consideration of the splendid annual reports of these productive groups, published both in *THE JOURNAL* and in the *Handbook for Delegates*.

Legislative Committee.—The year 1945 was a legislative year. The Legislative Committee was busy with

64 bills of interest to the practitioner of medicine. As indicated above, our 237 legislative keymen throughout the state were kept advised on developments through the weekly Legislative Bulletin. No proposed legislation that would have lowered high medical standards was enacted into law in 1945. Our special thanks goes to the Legislative Committee and particularly Chairman *H. A. Miller, M.D.*, of Lansing for a successful year in 1945.

The Special Committee on Radio was one of the most active Committees during the past 10 months, contributing scores of hours to Michigan's pioneering experiment in utilizing commercial radio to present Medicine's story. A perusal of this Committee's Annual Report is invited to the special attention of every Delegate.

A Drafting Committee for National Legislation, to develop a concrete program setting forth what the medical profession desires in legislation along the socio-economic lines, was appointed by the Executive Committee of The Council in February 1945. The Outline, developed by the Drafting Panel, was approved by the Executive Committee in May and was sent to other state medical societies in order that a composite plan might be presented in the near future to Congress, through the AMA Council on Medical Service and Public Relations. The Drafting Panel's work represents one of the highlights in the accomplishments of the State Society during the past year.

The Cancer Committee, in co-operation with various civic organizations of Michigan, is developing a series of cancer detection clinics—a worthwhile effort in cancer control.

Scientific Work—The Committee on Scientific Work arranged an excellent program for the 1945 Annual Session in Detroit. However, the War Committee on Conventions has to date (July 10) not given approval to the holding of this Conference on Postgraduate War Medicine, so the work of the Committee has come to naught. If the session can be held, however, the quality of the program will merit much praise for the Committee, as in the past.

Postgraduate Medical Education—Despite wartime restrictions and limitations on manpower, travel, et cetera, the Committee on Postgraduate Medical Education continued this year to offer a high quality program in postgraduate work to Michigan physicians.

The Postgraduate Foundation Committee accomplished a monumental task during the past year in developing the "Michigan Foundation for Medical and Health Education." This Foundation will be incorporated after an organization meeting, to elect a Board of Trustees and to carry on routine business, is held in September. The Foundation will become the successor of the MSMS Foundation for Postgraduate Medical Education created by the Society in 1942. The Committee members merit great thanks for their sacrifice of many hours in working out the technical and legal details of this important project. A recommendation on this subject follows.

The Industrial Health Committee again sponsored a successful Postgraduate Industrial Conference in Detroit on April 5.

The Child Welfare Committee and the Heart and Degenerative Diseases Committee, with the co-operation of the Michigan Crippled Children Commission and its Director, *Carlton Dean, M.D.*, developed a joint program on Rheumatic Fever Control which represents "another first for Michigan." This project to study and develop care and prevention projects includes case finding and diagnosis of rheumatic fever in persons in the indigent categories and those referred by their family physician for consultation. Nine diagnostic centers have been setup covering all areas of the State. The co-operation of all doctors of medicine in the State is urged in this effort to control a killer among children.

Contacts with Governmental Agencies

1. *The Committee on Physical Rehabilitation, and its advisory Committee on Uniform Fee Schedule for Governmental Agencies*, (committees of The Council) made a contribution to the profession that merits detailed explanation:

The Committee on Physical Rehabilitation was created by The Council on September 25, 1944, in Grand Rapids to act as advisors to the Vocational Rehabilitation Division of the State Board of Control for Vocational Education, State of Michigan. The Committee, composed of C. L. Hess, M.D., W. E. Barstow, M.D., Carleton Dean, M.D., R. S. Morrish, M.D., and E. F. Sladek, M.D., held four meetings: on October 22 and December 3, 1944, January 7 and January 25, 1945.

Details of the Federal Act, the Rules and Regulations, and the Manual of Policies governing the federal-state physical rehabilitation program were discussed in detail with representatives of the State Board of Control for Vocational Education and of the Michigan Social Welfare Commission at the first two meetings. The group to be covered under Public Law 113 of the 78th Congress includes:

1. Disabled individuals (persons unable to work because of their disability);
2. War disabled civilians—such as Civilian Defense, Aircraft Warning Service, Civil Air Patrol, etc.;
3. Civil employes of the United States—such as employes of OPA, et cetera—generally those not covered under U. S. Civil Service.

The State Vocational Rehabilitation Division encourages the physician-patient relationship, to achieve best results with the patient; its policy is based on economic need, the Division furnishing only necessary services beyond the financial ability of the patient to pay and where the services cannot be obtained elsewhere.

The Committee approved simple, short report forms, for use by the State Division; upon invitation, it aided the State to find a medical consultant and supervisor of the physical restoration program, in the persons of B. H. VanLeuven, M.D., formerly of Petoskey. It also recommended to the MSMS Council the development of a uniform fee schedule for all governmental agencies: the Committee recommended that the fees in this schedule be considered the minimal fee for the service named, subject to upward revision in unusual cases—these unusual cases to be reviewed by a special board of doctors of medicine; the Committee also recommended the creation of an advisory or sub-committee of five members, representing different areas of the state, to develop from data on hand and other data available this uniform medical and surgical fee schedule for governmental agencies.

The Committee expressed its thanks to Michigan Medical Service, its officers and its Fee Schedule Committee, for aid in developing from co-ordinated fee schedules, the uniform fee schedule. It also expressed appreciation for the co-operative attitude of H. Earle Correvont, Chief, and Miss Katharine Post, Medical Social Work Consultant, of the Vocational Rehabilitation Division, State Board of Control for Vocational Education, and Lynn G. Kellogg, Supervisor; and Magnolia Culver, Assistant, of the Michigan Social Welfare Commission.

The Committee has been of value not only to the State but to the medical profession and the people they serve in bringing forth a better understanding of medical problems in connection with the physical restoration program which portends to be of vast proportions and great consequence in the postwar era.

2. *Uniform Fee Schedule for Governmental Agencies*—At its February 1945 meeting, the Executive Committee of The Council adopted the following resolution: "In the light of modern conditions, changes, and trends, and the creation of new groups and categories—since

in the past the medical profession has sold its commodity of service to governmental agencies at less than cost—that the minimal fee in the future shall be commensurate with the work done." This action followed a discussion that the time seems to be here to withdraw the philosophy of a special discount rate to government for care of indigents and that this ideology must be changed before the profession can insist on a uniform fee schedule for governmental wards.

Acting upon the recommendation of the Committee on Physical Rehabilitation, The Council appointed the Committee on Uniform Fee Schedule for Government Agencies, composed of R. L. Novy, M.D., A. B. Smith, M.D., C. E. Toshach, M.D., Frank Van Schoick, M.D., and E. R. Witwer, M.D. This Committee is actively engaged in the great task of formulating a uniform fee schedule for wards of government and indigents. Distribution of this prospective fee schedule has been made to all county societies and to all specialist societies; contacts will be made with all staffs of hospitals in order to obtain a representative uniform fee schedule for presentation to The Council and to the Society. The work at the time this report was written (June 10, 1945) is incomplete. *A recommendation on this subject follows.*

3. *The U. S. Veterans Administration* has for some time been circularizing hospitals with a form of contract entitled "Proposal for the Hospital or Sanatorium Care of Beneficiaries of the Veterans' Administration." The present edition of this proposal was revised in August, 1944, and is known as Supply Form 1269. In effect, it is an offer on the part of a hospital to furnish and sell to the Veterans' Administration not only hospital services, but medical and dental care, as well. Payment is to be made not to the physician or dentist, but directly to the contracting hospital. In the opinion of the general counsel, the agreement is one for medical practice by a hospital, and is clearly objectionable. *A recommendation on this subject follows.*

4. *Office of Veterans' Affairs*—At the request of this recently created department of state government, a Liaison Committee was appointed to work mutually for the benefit of returning veterans, including medical officers. An initial meeting of this Committee with Governor Harry F. Kelly, Colonel Philip C. Pack, and Major A. D. Alguire has already justified this liaison.

5. *Michigan Crippled Children Commission*. Splendid co-operation continues to exist between the Michigan Crippled Children Commission and the Michigan State Medical Society. The inauguration of the pioneering project in rheumatic fever control is a striking example.

6. *Sub-Committee to Investigate Aid to Physically Handicapped of Committee on Labor, U. S. House of Representatives*—Upon invitation, twenty representatives of the MSMS attended a hearing of this federal Sub-Committee, held in Detroit April 19-20, 1945. The medical viewpoint was presented during a full day's discussion of the physically handicapped in Michigan.

7. *Representatives of the United States Public Health Service* visited Detroit May 2, 1945, to study Michigan Medical Service. Officers of the MSMS met with the Washington representatives, to furnish them the medical viewpoint on Michigan's group medical care program.

8. *School of Occupational Health, Wayne University*—Raymond Hussey, M.D., Dean of this new School, outlined to the Executive Committee the pattern of his institution and sought the help of the medical profession in obtaining a qualifying board for industrial physicians and in assuming control of the new field of occupational analysis.

9. *A Senate Committee of the Pennsylvania Legislature* heard in April the testimony of two MSMS representatives concerning Michigan Medical Service. Officers of the Medical Society of the State of Pennsylvania had called upon MSMS for help in defeating a bill offered by a Blue Cross Plan director in Pennsylvania which would have given control of medical service pro-

grams in that State to group hospitalization organizations. The Michigan representatives, President Brunk and Secretary Foster, certified to the harmony existing between Michigan Medical Service and Michigan Hospital Service in the administration of the health service program in Michigan, to prove that an efficient organization can be developed with the complete separation of medical care and hospital service.

10. *The Mackinac Island State Park Commission* presented to The Council a gavel, made from part of a log from the Early House, scene of Beaumont's original experiments on Mackinac Island. The "Beaumont Gavel" was used for the first time at the meeting of the Executive Committee of The Council, November 9, 1944.

11. *E.M.I.C. Recommendations* adopted by the Steering Committee on Health Services Advisory to the Children's Bureau, U. S. Department of Labor, adopted January 28, would give the Children's Bureau almost unlimited powers. It places the Bureau into the field of public health where it does not belong and places a large section of the practice of medicine under the domination of a lay-controlled bureau. The Council is strongly of the opinion that the war should not be used as an excuse for this Bureau to enlarge its powers or should the Bureau be allowed to increase its powers during wartime. *A recommendation on this subject follows.*

Contracts with Non-Governmental Agencies

1. *The Michigan Physicians' Committee* was organized in Detroit on October 11, 1944, with the assistance of the State Society officers. This is a branch of the National Physicians' Committee.

2. *American Association of Physicians and Surgeons*, Gary, Ind. The objectives of the AAPS were approved in principle by the Executive Committee of The Council on March 22, 1945. The work of the Michigan State Medical Society in seeking pledges of co-operation from its members against compulsory political medicine is identical to the aims and activities of the AAPS.

3. *Michigan Medical Service* reimbursed the Michigan State Medical Society for the original (1939-40) organizational expense in the total sum of \$17,544.45, at The Council's annual session January 26, 1945. Michigan Medical Service has been in the black for many months, has over 800,000 subscribers, 21 branch offices, and cash on hand of over \$1,200,000. It is the largest and most successful voluntary medical service plan in the world—and is run by the Michigan medical profession! *A recommendation on this subject follows.*

4. *The Michigan Health Council* is carrying on an excellent and very comprehensive program of public relations. It is living up to its slogan: "A non-governmental organization to advance the health of the people." Its printed program entitled "Better Care for the People of Michigan" is commended for perusal to all members of the Michigan State Medical Society.

Matters Referred to The Council by 1944 House of Delegates

1. *By the adoption of the Dibble Resolution*, the 1944 House of Delegates decided that, following the present emergency, steps be taken to clarify the status of osteopaths with particular reference to their practice of therapeutics. It was further concluded that, for the present, an approach to an eventual solution be made by studying Nebraska court decisions and the attitudes of medical societies in other states. The study of judicial decisions was in due course referred to our General Counsel who has been making an examination of the field of statutory and judicial law of a number of states with reference to the subject. Unfortunately, there is within the several states of the union a complete lack of uniformity in statutory law concerning the practice of osteopathy. Furthermore, the definition and limitations of osteopathic practice are in most statutes so vaguely prescribed that they require judicial interpretation. These

court decisions are, of course, as varied as is the statutory language sought to be interpreted. It follows, therefore, that the cases require not only careful analysis, but will, in many instances, be of little value in a state having a statute employing a substantially different definition or description of osteopathic practice. Nevertheless, there is now in progress a study of legislation which bears a reasonable similarity to the laws of this state, as well as an examination and collection of judicial interpretations of such laws. The result of this research will be made available in the near future in more extended form for consideration as to postwar action by the Michigan State Medical Society.

2. *University of Michigan Hospital policy of reporting to certain practitioners*—A letter on this subject was addressed to the President of the University of Michigan who suggested that an MSMS Committee meet with University Hospital executives to discuss this matter. The meeting held June 21 in Ann Arbor, brought out the following: Approximately 20 cases per month are referred to the University Hospital by osteopaths, some being admitted to the hospital but more being handled as outpatients. A ruling exists on reports returned to referring osteopaths which indicates that the reports shall give the inclusive dates of the study of the patient, the diagnosis, the recommendation in general, but nothing pertaining to medication; all departments of the University Hospital are directed to be brief and terse in these reports and not descriptive. The University Hospital authorities believe there is a legal obligation to receive the patients of referring osteopaths because, in the language which designates qualifications for admission to the University Hospital, the words "referred by physicians" is not qualified.

3. *MSMS Medical Veterans' Readjustment Program*. This subject was discussed at every meeting of The Council and of the Executive Committee since the resolution to create the Readjustment Program was adopted by the House of Delegates last September. The development of the Program was referred to and discussed not only by the County Societies Committee of The Council but by a Special Committee created early in 1945.

When the House of Delegates met in 1944, the General impression was that the European war would end in just a few weeks and that the return of many medical veterans was imminent. V-E day did not arrive until May 1945, and present reports would indicate that the personnel of the medical corps will not be separated from service in large numbers for some period of time—perhaps several years. The Dean of the University of Michigan Medical School reported to the Executive Committee that according to recent statistics, a great many doctors will perhaps be needed in future years for the national services; the supposition is that 36,000 of the present 60,000 doctors in Military Service (47,000 in the Army and 13,000 in the Navy) may be utilized after the war's end in the following capacities: 5,000 in the USPHS, occupied territories and foreign educational institutions, 10,000 in the Veterans' Administration, 10,000 basic complement for the standing army compulsory military training program, and 5,000 for the Navy, thus only 30,000 medical officers might be expected to return to civilian practice and the high point of demobilization might not take place until 1948 for the Army and 1950 for the Navy. In the immediate future, therefore, it would appear that the need for postgraduate work for returning medical veterans will not be great.

However, the greatest job awaiting the medical profession—when the bulk of medical officers do return—will be the furnishing of adequate postgraduate services. Two main groups will be serviced:

- (a) The young Doctor of Medicine who has had his education interrupted or abbreviated;
- (b) The older men who want refresher courses prior to return to practice or prior to entering a specialty.

In December 1944, President Brunk sent a letter to every Michigan medical man in military service asking him what he desired in postgraduate work, et cetera, upon his return from military service; the response to this communication was most gratifying and gave the State Society some definite information upon which to pursue its studies.

A co-operative program of postgraduate activity is being worked out by the University of Michigan, Wayne University, Eloise Hospital, Kellogg Foundation, and Michigan State Medical Society; in addition, the Office of Veterans' Affairs, State of Michigan, is of valuable service to returning medical officers.

The Special Committee's program is to (a) make postgraduate plans; (b) to meet thereafter with officials of the Office of Veterans' Affairs who will attempt to secure sufficient funds to carry out the program; (c) to meet with the medical schools and teaching hospitals to discuss inauguration of additional postgraduate courses. The Executive Committee recommended to the Committee on Postgraduate Medical Education that it so arrange its program for medical veterans that the returning officer may receive credit from the American Boards.

The need for a full-time or part-time Counselor and Adviser was given extensive study; the Executive Committee feels that, for the present, the work of assisting medical veterans can be handled by the MSMS Executive Office and the Office of Veterans' Affairs, State of Michigan, working in co-operation.

The Council has segregated the funds of the Medical Veterans' Readjustment Program so that any expenditures of the income arising from the special \$5.00 assessment shall be limited to the specific purposes outlined in the 1944 House of Delegates resolution. No part of this fund of \$16,281.25 has been spent, to date (July 10, 1945).

A booklet of information for medical veterans is being drafted through the co-operative work of the Office of Veterans' Affairs, State of Michigan, and the MSMS Executive Office. It is to be noted that the MSMS Medical Veterans' Readjustment Program will serve a useful and worthy purpose in its proper time, and will fill in the gap of the state and federal programs, so far as returning medical veterans are concerned. The Program will be ready when our Military Members who are separated from service need it.

Miscellaneous

1. *Medical-legal.* Only one medical-legal case, inherited from the days when the Michigan State Medical Society offered medical-legal protection to its members, remains on the records of the Trustee. It is anticipated that this case will be adjudicated shortly, leaving the slate clear.

2. *Compulsory political medicine.* Two compulsory health insurance proposals were introduced into the Michigan Legislature in 1945. They were similar to a proposal sponsored in California by the CIO, which bill never came out of Committee; the same fate met the Michigan edition.

The serious threat of these proposals must be recognized by the doctors of this State. The medical profession must expand its own *voluntary* programs for more complete distribution of medical care—at once—or it may expect the possible imposition of a most objectionable program of compulsory political medicine in this state.

Pledge cards, indicating a united stand against political medicine, were forwarded on two occasions to all members of the MSMS during the past year. The results were not encouraging, approximately 1,700 out of the MSMS membership having been returned.

The Michigan Survey of Public Opinion indicated certain "pet peeves" of the people concerning flaws of the medical profession. (6.5% felt that doctors overcharge; 4.4% complained that physicians keep patients

waiting; 1.7% are of the opinion that doctors lack interest in their patients; and 5.6% felt that doctors are dishonest). While the percentage was not high, the elimination of these complaints is the first responsibility of every individual practitioner of medicine and the medical profession as a whole.

In June, President Brunk forwarded letters to 1,400 leading industrialists, bankers, civic leaders, et cetera, of the United States, outlining the various attempts to socialize Medicine and seeking their advice and co-operation; he enclosed a reprint suggesting that a "National Health Congress" might be incorporated, to ban together doctors of medicine, dentists, hospital executives, pharmacists, et cetera, in a joint stand against compulsory political intrusion. The comments from these influential laymen were in the main encouraging, but proved that a great task faces the medical profession—*MUCH WORK MUST BE DONE*. The selling job of the medical profession must be done in the next 15 months, in advance of the time when adverse legislation might be introduced in our State. It can be done by daily action and unity of purpose. *A recommendation on this subject follows.*

Recommendations

The Council recommends:

1. That the members of the Michigan State Medical Society should consider themselves individually and collectively responsible for spreading beneficial information regarding Michigan Medical Service, whenever and wherever they can, since it represents a voluntary program created and maintained by the Michigan medical profession, and is to be preferred both by the people and by doctors of medicine to compulsory political schemes now being zealously advocated by *interested* laymen.

2. That the House of Delegates give favorable consideration to a resolution attesting the appreciation of the Michigan medical profession on the home front to those of its members who are serving in the armed forces.

3. That the Michigan medical profession unite as one behind the proposed uniform fee schedule for governmental agencies; that the House of Delegates urge individual members and county or district medical societies to make special efforts immediately to negotiate necessary revisions in schedules of benefits covering governmental wards so that individual members are not penalized by being forced to perform services at a financial loss and below the fees indicated in the uniform fee schedule for governmental agencies.

4. That the House of Delegates reaffirm its authorization to The Council either to levy a capital assessment or assessments, not to exceed a total of five dollars, or to increase the dues of the State Society for the calendar year 1946 by a sum not to exceed five dollars, in addition to the present annual dues, to meet the ordinary expenses of the Society as seems justified in The Council's considered opinion.

(It is noted that this request of The Council was granted by the House of Delegates in 1938-1939-1940-1941-1942-1943-1944 but was never invoked. The request for the five-dollar assessment is not to be confused with the ten-dollar assessment voted by the 1943 and 1944 House of Delegates for special public educational activity; no part of these ten-dollar assessments has been used for the *ordinary* expenses of the Michigan State Medical Society).

5. That, in connection with the Veterans' Administration, the best type of medical and surgical care is obtainable in the veterans' home community, given by his family doctor of medicine; it recommends the use of these facilities to the U. S. Veterans' Administration. It further recommends (a) that the Michigan State Medical Society voice to the American Medical Association its firm objection to the form of its present contract with hospitals, and suggest that an endeavor be made to have the Veterans' Administration modify the proposed contract so as to avoid the practice of medicine by a

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hospital; (b) that the Michigan State Medical Society make known to the Michigan Hospital Association its serious objection to this type of contract; and (c) that the Michigan State Medical Society make clear to the doctors of medicine of this State, through proper publicity, its position with respect to the proposed Veterans' Administration contract.

6. That the House of Delegates consider a resolution instructing that a letter be sent to every U. S. Senator and Congressman from Michigan asking that the U. S. Children's Bureau be given no appropriation for new or expanded services.

7. That the individual members of the House of Delegates encourage other doctors of medicine, as well as laymen interested in sound medical service and education, to contribute during life and in their last wills to the Michigan Foundation for Medical and Health Education.

8. That every individual Doctor of Medicine in Michigan strongly oppose all attempts leading to a complete compulsory sickness insurance program organized and maintained by government (as proposed in the Wagner-Murray-Dingell Bill of 1945); that they fight in a *positive way* to defeat such schemes by (a) eliminating any flaws that may result in complaints on the part of patients; (b) encouraging Michigan Medical Service, the voluntary program sponsored and operated by the Michigan medical profession itself—the greatest and most successful group medical care plan in the world; (c) by working with patients and the people generally, especially those in political office, to explain the benefits of a present system based on the time-tried private practice of medicine and the preservation of the physician-patient relationship which has made American Medicine the greatest in the world. Let's keep it that way!

Respectfully submitted,

E. F. SLADEK, M.D., *Chairman*

O. O. BECK, M.D., *Vice Chairman*

R. S. MORRISH, M.D., *Chairman, Publication Committee*

O. D. STRYKER, M.D., *Chairman, County Societies Committee*

C. E. UMPHREY, M.D., *Chairman, Finance Committee*

PHILLIP A. RILEY, M.D.

WILFRID HAUGHEY, M.D.

R. J. HUBBELL, M.D.

A. B. SMITH, M.D.

T. E. DECURSE, M.D.

W. E. BARSTOW, M.D.

F. H. DRUMMOND, M.D.

A. H. MILLER, M.D.

W. H. HURON, M.D.

DEAN W. MYERS, M.D.

E. R. WITWER, M.D.

P. L. LEDWIDGE, M.D., *Speaker*

A. S. BRUNK, M.D., *President*

L. FERNALD FOSTER, M.D., *Secretary*

WM. A. HYLAND, M.D., *Treasurer*

ANNUAL REPORT OF THE RADIO COMMITTEE, 1944-45

The radio program of the Michigan State Medical Society for the year 1944-45 continued without change following the program for the year 1943-44. The broadcasts were given over station WJR on Thursday evenings at 11:30. The report for the year 1943-44 included the broadcasts through July 27, 1944. The following speakers and subjects comprised the program from August, 1944, through February, 1945, when the program was discontinued.

August 3—H. Marvin Pollard, M.D., Assistant Professor of Internal Medicine in the University of Michigan Medical School: Chronic Indigestion.

August 10—Jacob D. Brook, M.D., Health Officer, Kent County Health Department, Grand Rapids, Michigan: What a Health Department Does.

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- August 17—Claude C. Cody, M.D., Instructor in Otolaryngology in the University of Michigan Medical School: Sinusitis.
- August 24—Harold F. Falls, M.D., Assistant Professor of Ophthalmology in the University of Michigan Medical School: Common Eye Complications in Childhood.
- August 31—Henry J. Lange, M.D., Instructor in Surgery in the University of Michigan Medical School: Cancer.
- September 7—Sture Johnson, M.D., Assistant Professor of Dermatology and Syphilology in the University of Michigan Medical School: Plant Dermatitis.
- September 21—Ferdinand Gaensbauer, M.D., Obstetrician and Gynecologist, Pontiac, Michigan: The Nutritional Aspects of Pregnancy.
- September 28—Albert C. Furstenberg, M.D., Dean of the University of Michigan Medical School: Impact of War Upon the Medical Profession.
- October 5—Jerome W. Conn, M.D., Associate Professor of Internal Medicine in the University of Michigan Medical School: Fat People and How They Get That Way.
- October 12—Samuel W. Donaldson, D.D., Roentgenologist, St. Joseph's Mercy Hospital, Ann Arbor: The Role of X-rays in Emergency Cases.
- October 19—Julius M. Wallner, M.D., Assistant Professor of Psychiatry in the University of Michigan Medical School: The Patient.
- October 26—James H. Maxwell, M.D., Associate Professor of Otolaryngology in the University of Michigan Medical School: Deafness.
- November 2—Otto K. Engelke, M.D., Health Officer, Washtenaw County Health Department, Ann Arbor: The Role of the Parent in the Control of the Dangerous Contagious Diseases.
- November 9—Gordon K. Moe, M.D., Assistant Professor of Pharmacology in the University of Michigan Medical School: Recent Advances in the Treatment of Thyroid Disease.
- November 16—Miss Rhoda F. Reddig, Professor of Nursing and Director of the University of Michigan School of Nursing: Some Answers to Questions Concerning Nursing.
- November 30—Carl A. Moyer, M.D., Director of Surgery at the William J. Seymour Hospital, Eloise, Michigan: The Dog and Modern Medicine.
- December 7—Herman H. Riecker, M.D., Assistant in Postgraduate Medicine in the University of Michigan: The Prevention of Heart Disease in Middle Life.
- December 14—Paul S. Barker, M.D., Associate Professor of Internal Medicine in the University of Michigan Medical School: Recent Advances in the Care of Heart Disease.
- December 21—Joseph G. Molner, M.D., Deputy Commissioner and Medical Director, City of Detroit Department of Health, and Assistant Professor of Preventive Medicine and Public Health in the Wayne University College of Medicine: Protection of Children Against Disease.
- December 28—Loren W. Shaffer, M.D., Director of Social Hygiene Division, City of Detroit Department of Health, and Professor of Dermatology and Syphilology in the Wayne University College of Medicine: The National Program for Venereal Disease Control.
- January 4—Robert L. Novy, M.D., Professor of Clinical Medicine in the Wayne University College of Medicine and President of the Michigan Medical Service: Prepaid Medical Care for the People of Michigan.
- January 11—Ralph H. Pino, M.D., Assistant Professor of Clinical Ophthalmology in the Wayne University College of Medicine and Editor of the *Detroit Medical News*: Exploring the Medical Frontiers.
- January 18—Bruce H. Douglas, M.D., Commissioner, City of Detroit Department of Health and Professor of Preventive Medicine and Public Health at the Wayne University College of Medicine: Health on the Home Front.
- January 25—Marvin Schwartz, M.D., Instructor in Medicine in the Wayne University College of Medicine: The Diabetic and His Problems.
- February 1—Frank H. Bethel, M.D., Associate Professor of Internal Medicine in the University of Michigan Medical School and Assistant Director of the Simpson Memorial Institute: Fatigue and Anemia.
- February 8—Charles W. Newton, Jr., M.D., Instructor in Obstetrics and Gynecology in the University of Michigan Medical School: Your Care During Pregnancy.
- February 15—William D. Robinson, M.D., Assistant Professor of Internal Medicine in the University of Michigan Medical School, in Charge of the Rackham Arthritis Research Unit: Your Food and Your Health.
- February 22—Isadore Lampe, M. D., Associate Professor of Roentgenology in the University of Michigan School: The Value of X-rays and Radium in Non-Cancerous Disease.

It is felt by the members of the Radio Committee of the Michigan State Medical Society that the committee has served its purpose. The program has been carried out with some difficulties. Inasmuch as the period donated by Station WJR it was of necessity at an undesirable time. This was regretted by the members of the committee both because of the fact that at the late hour there were few listeners throughout the State of Michigan and also because of the fact that it seemed to be an imposition to ask speakers to participate at such a late hour. In our report of last year we suggested that a permanent committee centering in the cen-

tral office of the Society could most effectively arrange the radio program and we also suggested that the Society obtain a permanent radio hour, possibly paid for through appropriations from the Society, so that the broadcasts could be continued throughout the year on a perennial or perpetual basis. The Michigan State Medical Society now has a regular weekly program, paid for by the Society. This is at a very desirable hour, at 7:15 p.m., Friday, and over a station with a wide broadcasting range. This program is now being participated in by the officers of the Michigan State Medical Society and the leaders in the profession in the State of Michigan. Radio broadcasting, it seems, is a function of either the Public Relations Committee or the Preventive Medicine Committee of the Michigan State Medical Society and for that reason it is felt that the broadcasting should continue to issue from the central office of the Society rather than from a committee made up of individual members, the personnel of which changes from year to year.

Respectfully submitted,

RUSSELL N. DEJONG, M.D., *Chairman*

EVERT W. MEREDITH, M.D.

WM. HAMILTON, M.D.

J. H. McMILLIN, M.D.

G. M. WALDIE, M.D.

FRANK WEISER, M.D.

ANNUAL REPORT OF SPECIAL COMMITTEE ON RADIO, 1944-1945

Some twenty-six meetings of the Special Committee on Radio were held since the 1944 Annual Session of the Michigan State Medical Society; at least three to four hours' deliberation was required at every meeting of the Committee, with additional special conferences on Sundays, making a total of approximately 100 hours' work—or twelve and one-half work days of eight hours each!

The Committee concluded Series No. I on October 21, 1944. This program broadcast over twelve stations of the Michigan radio network, consisted of thirty-two five-minute dramatic episodes.

Series No. II of "American Medicine" was developed, after much thought and many conferences. It began February 16, 1945, and represented twenty fifteen-minute broadcasts over Radio Station WJR, the most powerful station in Michigan. It consisted of a program of song and music and a message from the family doctor. The broadcasts were given every Friday evening at 7:15 p.m. EWT and were "live," not transcribed. A story contest, inaugurated as one of the features in the WJR presentations, also represented much time on the part of members of the Special Committee on Radio in reading the many letters of the contestants. The second series in the MSMS commercial radio program ended July 6.

Detroit Public Relations-Radio Conference

In order to bring the story of Michigan's medical public relations experience to the executives of the more populous states in the east and middle-west, the Special Committee on Radio, with the gracious approval of the Executive Committee of The Council, invited (through a telephone conference on April 5) the presidents of seventeen state medical societies to attend a Public Relations-Radio Conference in Detroit on April 27-28. All seventeen presidents, together with other officers of the following medical societies, were present: Connecticut, Delaware, Illinois, Indiana, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Wisconsin and the District of Columbia.

The Detroit Conference was an outstanding success and resulted in an enthusiastic response from the medical society officials present at the two-day meeting. Not

only was the commercial radio program of the Michigan State Medical Society presented, but also the need for creation of Drafting Panels to prepare necessary medical legislation, and a complete exposition and tour of Michigan Medical Service. The 17 presidents went on record as approving an immediate expansion of commercial broadcasting by the medical profession, and the creation of Drafting Panels in all states for purpose of presenting recommendations for necessary medical legislation to Congress, through the AMA Council on Medical Service and Public Relations.

A working Committee of seven presidents was authorized by the Conference. This group met in Buffalo May 24 to draw up specific recommendations for presentation to the executive bodies of the states represented at the Detroit Public Relations Conference.

The Chairman of this Committee went to Boston, at the invitation of the Massachusetts Medical Society, and addressed the Council together with the presidents and secretaries of component county medical societies of that state in May. He also attended a conference in New York of the Executive Committee of the Medical Society of the State of New York; also upon invitation, a meeting of executives of the New York County Medical Society and heads from the five Boroughs in New York City. The value of greater public relations by the medical profession was thoroughly explored.

Denver Public Relations Conference. At the invitation of executives of western states medical societies, representatives of the Michigan State Medical Society attended the Denver Conference of June 28-29. The Michigan men were invited to outline and explain the progressive activities of Michigan State Medical Society.

Series No. III of the MSMS radio program was studied by the Special Committee on Radio which referred its data to the Executive Committee of The Council, for final action.

The individual members of the Special Committee on radio had no concept of the time they would have to spend in working out the many details presented to this Committee. It has been a labor of love trying to sell the medical profession on a necessary idea which we are afraid some may appreciate and arrive at too late.

The Special Committee on Radio wishes to express sincere thanks to the members of The Council and its Executive Committee for encouragement and help in its projects of the last ten months.

The Committee also is grateful to the doctors of medicine who at great inconvenience of time and effort visited Detroit to carry the message of a "family doctor" in Series II of the MSMS radio program. These doctors were: W. E. Barstow, M.D., St. Louis; O. O. Beck, M.D., Birmingham; A. S. Brunk, M.D., Detroit; C. L. Candler, M.D., Detroit; T. E. DeGurse, M.D., Marine City; F. H. Drummond, M.D., Kawkawlin; L. Fernald Foster, M.D., Bay City; Wilfrid Haughey, M.D., Battle Creek; L. J. Hirschman, M.D., Detroit; R. J. Hubbell, M.D., Kalamazoo; Wm. A. Hyland, M.D., Grand Rapids; S. W. Insley, M.D., Detroit; P. L. Ledwidge, M.D., Detroit; H. A. Luce, M.D., Detroit; H. A. Miller, M.D., Lansing; R. S. Morrish, M.D., Flint; D. W. Myers, M.D., Ann Arbor; J. M. Robb, M.D., Detroit; E. F. Sladek, M.D., Traverse City; O. D. Stryker, M.D., Fremont; C. E. Umphrey, M.D., Detroit; and E. R. Witwer, M.D., Detroit.

The Committee thanks, with sincerity, Mr. C. H. Chapman of the Chapman Agency, Detroit, which handled the technical details of this project. Mr. Chapman injected much of his own boundless enthusiasm and energy into the MSMS radio program, far more than could have been expected from the small commercial interest of this account. We appreciate the personal concern and constant help—greatly surpassing the routine of service—which Mr. Chapman gave our Committee and the medical profession of the State of Michigan.

The Chairman expresses his true appreciation for the ever-present advice of President Brunk and the literary

aid of Speaker Ledwidge in editing scripts. No Chairman was ever blessed with better committee members!

The Special Committee on Radio has attempted to bring the message of Medicine to the millions in Michigan and near-by states which listen to Radio Station WJR. It has stressed the value to the people of the time-tried method of private practice to medicine and the physician-patient relationship which have made American Medicine the greatest in the world. "Let's Keep It That Way" has ended the doctor's message every week.

Respectfully submitted,

C. L. CANDLER, M.D., *Chairman*
A. S. BRUNK, M.D.
P. L. LEDWIDGE, M.D.

ANNUAL REPORT OF THE POSTGRADUATE FOUNDATION COMMITTEE, 1944-1945

Two meetings of the Postgraduate Foundation Committee were held during the year, one in December, 1944, at Ann Arbor, attended by Earl I. Carr, M.D., Frederick B. Miner, M.D., J. Milton Robb, M.D., Rollin H. Stevens, M.D., and James D. Bruce, M.D.; and one in Lansing at Dr. Carr's office, in May, 1945, with Drs. Carr, Burton R. Corbus, and Bruce present.

At the December meeting the very extensive correspondence between the members and the chairman was thoroughly reviewed and the objections, raised principally by Dr. Carr and Dr. Miner to the Original Trust Agreement presented by The Council, unanimously sustained. A revision of the Agreement or a new instrument was deemed necessary for the changes which seemed necessary to attain The Council's objective.

Since the chairman was to be out of the State for several months, Dr. Carr was named acting chairman and undertook to assemble the views presented by the committee into a new instrument for the consideration of The Council. Inasmuch as the changes in the Trust Agreement constitute the committee's most important contribution for the current year, I am taking the liberty to request that Dr. Carr present the report from the December, 1944, meeting to date.

With this request to Dr. Carr goes the committee's deep sense of obligation for a fine contribution in an area in which its members are deeply interested. Also, may I express the appreciation of the committee for the contributions of Dr. Miner and our profound regret at his untimely passing.

Respectfully submitted,

JAMES D. BRUCE, M.D., *Chairman*

* * *

The culmination of the work by the Postgraduate Foundation Committee is the completion and approval of the Articles of Incorporation and of the By-Laws and the readiness for the organization meeting incorporating the *Michigan Foundation for Medical and Health Education*. The activities, in brief, of the committee for this year follow:

On December 14, 1944, the Postgraduate Foundation Committee met with the Executive Committee of The Council and proposed plans for a Michigan Foundation. The Committee was instructed to continue its work, to employ legal counsel, and to report to The Council of MSMS at its annual meeting in January.

Trust company officials, lawyers and various financiers were consulted and Articles of Incorporation were sketched and tentative By-Laws were drawn up. These were presented to The Council on January 25 and the

Committee's work on the Articles of Incorporation was approved by The Council after a thorough presentation and discussion. The purposes which appear in the Articles of Incorporation are:

"To acquire, provide, use, develop, endow and finance methods, means and facilities for Postgraduate education in medicine, for education in medicine, for lay health education in medicine, and for research, fellowships and scholarships, all in such manner as the Trustees shall determine. This corporation is organized and shall be operated exclusively for benevolent, scientific and educational purposes and its property shall be used by it solely for the purposes for which it is incorporated."

After general and special consideration and study, the following was determined by The Council as a part of the By-Laws:

"Membership shall be composed of The Council of MSMS, the six members of the Postgraduate Foundation Committee, the elected Board of Trustees of this corporation, and others elected to membership by the members. The Board of Trustees shall be composed of six physicians and three laymen selected from within or from without the membership and wholly with regard to qualifications in administration, business and finance and for special interest and knowledge in the needs and purposes of this corporation."

This structure, then, provides a membership of the corporation synonymous to stockholders and similar to the *Michigan Medical Service* corporation setup.

The Postgraduate Foundation Committee was instructed to appear before the Executive Committee of The Council in February and present the finished Articles of Incorporation, as corrected and amended, and legally prepared By-Laws.

This report was continued at the May meeting of the Executive Committee.

There now remains the incorporation of the Foundation which the Executive Committee voted at its May meeting to take place in September at the time of The Council meeting. Legal approval of the work of this committee has been given to The Council in the language of the minutes of the meeting on June 13, 1945, of the Executive Committee of The Council: "General Counsel reported that the Articles of Incorporation and the By-Laws of the 'Michigan Foundation for Medical and Health Education' were in good legal form and presented a workable program."

The salient points of the *Michigan Foundation for Medical and Health Education* are to be discerned in the purposes of the organization and in the selection at the organization meeting of an able and cognizant Board of Trustees. We will look to them for judgment, planning, growth, and development of finance and administration but the State Society will continue to direct academic programs as in the past. The creation of a sound and legal medical foundation which should meet the approval of potential donors and their lawyers and trust companies is no longer a chimera but is, today, a reality, pending proper actions of an organization meeting and the filing with the State of Michigan of prepared documents herewith attached. For convenience and easy inspection, a synopsis is also attached.

Respectfully submitted,

E. I. CARR, M.D., *Acting Chairman*
JAMES D. BRUCE, M.D., *Chairman*
BURTON R. CORBUS, M.D.
FREDERICK B. MINER, M.D., (*deceased*)
J. MILTON ROBB, M.D.
ROLLIN H. STEVENS, M.D.

**ANNUAL REPORT OF MSMS REPRESENTATIVES
TO JOINT COMMITTEE ON HEALTH
EDUCATION, 1944-45**

There has been no meeting of the representatives to the Joint Committee on Health Education during this past year, and there has been no activity by the Committee for nearly three years. The last contribution of The Council to this committee has been kept intact.

At the last meeting of the representatives, it was thought advisable to maintain the organization with the thought that we might, in the future, find an activity which would be worth while, and several suggestions were made, none of which seemed feasible, during this war period, to carry out. It is, of course, apparent that the laity is now being approached with health education programs from many directions. One need only to mention the work of the Society in Cancer Education, Venereal Disease Education, and, in a general way, through the radio programs, the latter an activity which, in earlier years, was sponsored by this same Joint Committee. In addition, there are such organizations as the Michigan Committee on Adult Education which covers a large field and on which the Joint Committee is represented by its chairman.

The Joint Committee, initiated, sponsored, furthered, and largely financed in recent years by the Michigan State Medical Society, has behind it nearly a half century of tradition, in which much has been accomplished. It seems to your chairman that it probably has outgrown its usefulness. If, in your opinion, this committee should be dissolved, then certain formal steps should be taken.

Respectfully submitted,
BURTON R. CORBUS, M.D., *Chairman*
ROBT. H. FRASER, M.D.
O. W. LOHR, M.D.
HENRY A. LUCE, M.D.
F. J. O'DONNELL, M.D.

**ANNUAL REPORT OF COMMITTEE ON HEART
AND DEGENERATIVE DISEASES, 1944-45**

The Subcommittee on Heart and Degenerative Diseases of the Preventive Medicine Committee held no formal meetings during the year. However, by correspondence it was agreed that the chairman should formulate a program on a state-wide basis for the control of rheumatic fever in conjunction with the Michigan State Medical Society.

The Executive Committee of the Council then set up a special committee combining the subcommittees on Pediatrics, Heart and Degenerative Diseases, and the Crippled Children's Commission, with Dr. L. F. Foster, as chairman. The Committee consists of Drs. Carleton Dean, Frank Van Shoick, L. F. Foster, and H. H. Riecker. It has had two meetings and has formulated a program for the control of rheumatic fever. This program was approved by the Executive Committee of the Council and involves the establishment of nine diagnostic groups in strategic arts of the State exclusive of Detroit to which physicians may refer cases for diagnosis and advice as to treatment. In the case of indigent children the expense of investigation and hospitalization will be borne by the Crippled Children's Commission.

A program of education of the laity as well as the medical profession was outlined and will be carried forward during the coming year. The diagnostic groups in the various centers are now being completed. As soon as they have been designated, letters will go out to all physicians in the State advising them of the mechanism of this service and what is contemplated in the control of rheumatic fever.

It is hoped in time that the facilities in the State for the diagnosis and care of rheumatic children will be equal to those for the control of tuberculosis. It is the

opinion of the committee that the program as arranged represents an advance in preventive medicine similar to that of the goiter control program initiated by the State Medical Society some years ago. The State profession should be congratulated upon the initiative taken in respect to one of the greatest scourges of childhood.

Respectfully submitted,
H. H. RIECKER, M.D., *Chairman*
M. S. CHAMBERS, M.D.
C. V. COSTELLO, M.D.
RALPH A. JOHNSON, M.D.
MARK MARSHALL, M.D.
A. E. VOEGELIN, M.D.

**ANNUAL REPORT OF CANCER CONTROL
COMMITTEE, 1944-45**

The Cancer Committee held one meeting this year, in December. Since that time we have not held any meetings, although the chairman has had several conferences with the American Cancer Society relative to the part the profession will play in their work. We believe we are gradually approaching an understanding as changes are being made in that organization.

In addition to this we have met with state officers of one of the large service clubs who expect to advocate aid in cancer detection as a project for their group in the coming year.

The following recommendations were approved by the Committee:

1. Support a "Cancer Teaching Day" under auspices of existing tumor clinics, combined with as much lay education as possible in that same area at the same time.
2. An annual cancer program in each county and district medical society meeting. A special cancer topic in each extramural graduate medical program.
3. A special cancer topic in each extramural graduate medical program.
4. An annual intensive postgraduate course in cancer diagnosis and treatment under direction of the Postgraduate Committee to be held in the two medical schools of Michigan.
5. That biology be made a required subject in all high schools and that teaching of cancer prevention and control be made a part of the regular health education teaching in high schools and colleges, but only under adequately trained teachers.
6. Support a plan for discussing cancer in high schools under direction of competent medical authorities supplied by the Cancer Control Committee of the State Society.
7. Recommend a frequent cancer page in THE JOURNAL of the Michigan State Medical Society. Also occasionally send to all members cancer bulletins emphasizing some important diagnostic or treatment point, such as recommending a curettagé for persistent or irregular bleeding.
8. That Cancer control be recognized in the teaching of public health in the School of Public Health in the University of Michigan and in similar courses in Wayne University. Chairman to contact the universities and ascertain to what extent cancer is taught in the public health program.

The Committee:

(a) Approved of cancer consultant services throughout Michigan to physicians desiring such services. This service to be furnished by the Michigan Department of Health without cost to the physicians through co-operation with the State Medical Society and its Postgraduate Committee.

(b) Approved the organization of special tumor services in any approved hospital when such services are offered by and through properly qualified and ethical doctors of medicine and when necessary facilities for such services are available.

(c) Recommended that the Cancer Control Committee

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be empowered to handle all cancer problems of the Society and to act on such problems as they arise.

Respectfully submitted,

WM. A. HYLAND, M.D., *Chairman*

J. H. COBANE, M.D.

F. A. COLLIER, M.D.

C. E. DEMAY, M.D.

C. K. HASLEY, M.D.

ROLLIN H. STEVENS, M.D.

E. C. TEXTER, M.D.

ANNUAL REPORT OF VENEREAL DISEASE CONTROL COMMITTEE, 1944-1945

Three meetings of the Venereal Disease Control Committee have been held during the past year. The first meeting was held at the Pantlind Hotel in Grand Rapids on September 28, 1944; the second in Lansing at the Porter Hotel on February 11, 1945; and the third at the Porter Hotel, Lansing, on May 20, 1945. The most important activities of the committee were as follows:

1. Arrangements for the preparation of an approved and improved chemical prophylactic kit by a suitable manufacturer and its adoption for state-wide distribution, through the Retail Druggists' Association, have at last been practically completed.

2. An educational article outlining the types of cases acceptable, and methods of treatment in use at the Rapid Treatment Center in Ann Arbor was prepared by the director, Nelson Ryan, M.D., and presented through this committee for early publication in *THE JOURNAL of the Michigan State Medical Society*.

3. An amendment to Michigan's Premarital Physical Examination Law was prepared and with the assistance of the MSMS Legislative Committee was successfully steered through the Legislature and received the governor's signature. It permits issuing of a special certificate for marriage by the State Health Commissioner where the woman concerned is pregnant regardless of the presence of venereal disease in either or both parties to the marriage.

4. A modification of the V. D. Report Form as prepared by N. W. Guthrie, M.D., and L. W. Shaffer, M.D., was approved by the committee for adoption by the State Health Department.

5. This committee is sponsoring a trip by Percy S. Pelouze, M.D., Philadelphia, throughout the state in September or October with the requested assistance of the Postgraduate Medical Education Committee and the Executive Office in outlining schedule or itinerary. Dr. Pelouze's expenses will be paid by the U. S. Public Health Service and his talks will cover the management of gonorrhea.

Respectfully submitted,

LOREN W. SHAFFER, M.D., *Chairman*

R. S. BREAKEY, M.D.

KENT A. ALCORN, M.D.

A. C. CURTIS, M.D.

RUTH HERRICK, M.D.

H. L. KEIM, M.D.

E. S. PARMENTER, M.D.

WM. R. VIS, M.D.

Committee voted to recommend that the suit be carried to a higher court if an opinion against Dr. Shaffer and the Detroit City Health Department is rendered.

Respectfully submitted,

NOBEL W. GUTHRIE, M.D., *Chairman*

R. S. BREAKEY, M.D.

H. L. KEIM, M.D.

L. W. SHAFFER, M.D.

ANNUAL REPORT OF COMMITTEE ON POST-GRADUATE MEDICAL EDUCATION, 1944-45

The Committee activities for the year 1944-45 have been carried on by correspondence because of travel difficulties and the increasing duties of the committee members incident to the war.

On December 5, 1944, a communication was sent to the members raising the following questions:

First.—Shall we attempt to resume the original semi-annual four-day program at this time?

All members favored the continuance of the two-day semi-annual schedule during the present emergency.

Second.—How many presentations are thought most desirable for each session?

Two thirty-minute presentations and one round-table discussion were favored.

Third.—A list of subjects for the April, 1945, program was submitted and the choice of the majority selected.

Lastly.—The final question is quoted in full:

We have felt for many years that the out-state program should be maintained financially by the Society as one of its important contributions to the improvement of medical service. Our teaching group has been consistently loyal and generous in their support which has often been given at very considerable financial sacrifice. The rate of compensation, \$27.50 a day, has little more than paid actual expenses. The Society is now said to be in a flourishing financial condition due to increased fees. I am wondering if you agree with me that increasing the ability of the practitioner to do better work and in wider fields constitutes the most important contribution which the Society can make to its members, and if more consideration should not be given in a material way to those members of our profession who have oftentimes at great sacrifice kept teaching appointments in all parts of the State? To this end I am suggesting for your consideration a flat fee of \$40 a day. This will not compensate most of them but it will at least show our appreciation. I shall be glad to have your opinion upon this point also.

Replies to this proposal were all favorable. Replies to this questionnaire were received from Drs. Drury, Fillinger, Furstenberg, Hess, Norris, Robb, Torgerson, and Walch. Members not replying were Drs. Brunk, Hull, and Pino. The replies received seemed to constitute a quorum being in fact greater in number than the usual attendance on a committee meeting.

On May 16, 1945, the following letter was sent to the committee members.

A number of rather important matters should be discussed by the Committee on Postgraduate Medical Education.

While I personally should like to meet with the Committee members, I realize the difficulty in calling men away from their busy practice during these times. Therefore, would you prefer that I prepare a letter discussing the program in mind and the other problems to be presented before the Committee—so that you can send your reactions to me? Or, would you like to attend a meeting in Detroit or Lansing on Sunday, May 27; Monday, May 28, or Sunday, June 3?

I enclose a "ballot" so that you may vote your wish. I shall abide with the decision of the majority.

All the members replied favoring the disposal of the matter by correspondence except one. Accordingly, the

ANNUAL REPORT OF JOINT VENEREAL DISEASE CONTROL COMMITTEE WITH STATE BAR OF MICHIGAN, 1944-45

One meeting was held May 20, 1945, in Lansing. Authority of the probate judges to issue marriage licenses under the Secret Marriage Law without requiring medical examination and certification was discussed. After reading opinions issued by the Attorney General, the Committee was convinced that probate judges do have this authority.

The suit now pending against L. W. Shaffer, M.D., and the Detroit City Health Department was discussed. This suit for \$5,000 is brought by a woman examined by the Detroit City Health Department as a result of their having a contact report from the Army. The

list of twenty-two subjects was sent out and the following received the highest number of votes:

1. Genito-urinary emergencies.....	6
2. Treatment of gonorrhea.....	5
3. Breech deliveries.....	5
4. Some practical consideration in the use of analgesic in the relief of pain.....	4
5. The avoidance of pitfalls in the diagnosis of gastro-intestinal complaints.....	4
6. Acute and subacute respiratory infections in childhood..	3
7. Rheumatic fever.....	3
8. Medical and surgical problems of the aged.....	3
9. Clinical investigation of the unconscious patient.....	3
10. Some fundamental precepts in anesthesia.....	3
11. The prevention and management of postoperative complications	3
12. The diagnosis and treatment of migraine and Ménière's syndrome	3

The voting as to second choice of subjects gave essentially the same results. A communication from Dr. Foster transmits the wishes of the Committee on Preventive Medicine that a presentation on rheumatic fever be repeated this fall. Dr. H. H. Riecker, Chairman of the Subcommittee on Heart and Degenerative Diseases, expresses the opinion that since *rheumatic fever* was included in last spring's program, it might be reserved until next spring on account of the greater prevalence of the disease in that season. Accordingly, numbers 1, 2, 3, 4, 5, and 6 have been selected for the autumn, 1945, program. As this subject matter is discussed with our instructors some changes undoubtedly will be necessary and it is not improbable that two of the above subjects might lend themselves advantageously to panels. Thus the final decision cannot be made at this time.

Some months ago Dr. Fred H. Drummond, Councilor of the Tenth District, called the attention of your committee to the difficulties in maintaining attendance from the local memberships in the Bay City-Saginaw area. The attendance in either city is excellent from the local membership but the combined meetings do not bring out commensurate attendance. The difficulty is thought to be due to the failure to adopt a day of the week suitable to both. It has been suggested that teaching centers be established in both cities. Inasmuch as the number of existing centers present many difficulties in travel and in obtaining the necessary instructional staff on account of the National Emergency, your committee does not feel that it can recommend an additional and independent center at this time. It is suggested by your committee that the Councilors of these districts should determine the sentiment of the members of the two areas and present this to the Council for its action. Your Committee hopes to have the Council's decision early enough to provide in the autumn program for any changes it may see fit to make.

The attendance on the extramural postgraduate courses for the year is as follows:

Ann Arbor	226
Battle Creek-Kalamazoo	121
Bay City-Saginaw	96
Flint	87
Grand Rapids	132
Lansing-Jackson	173
Mt. Clemens	39
Traverse City	73
Upper Peninsula	72

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A postgraduate medical conference of the University of Michigan Medical School was held in Ann Arbor, on October 13, 1944, with 141 physicians in attendance. The MSMS Industrial Health Committee in conjunction with the Department of Postgraduate Medicine of the University of Michigan held its annual conference in Detroit on April 5, 1945, and was attended by 83 physicians. The annual Ingham County Clinic was held in Lansing, on May 3, 1945, with approximately 200 physicians in attendance. The Cancer Committee of the MSMS and the Michigan Department of Health sponsored a one-day teaching program on cancer at Traverse City, on March 9, 1945, which was attended

by 38 physicians. The Department of Postgraduate Medicine at Ann Arbor gave the enrollment in the intramural postgraduate courses for the year as 488.

At the outbreak of the war some thought was given to discontinuing the extramural teaching. It was decided however to reduce the extramural program by one-half and to make an attempt to maintain our activities within the framework of the plan. It is a source of gratification to report that while our state profession has been depleted by approximately forty per cent, and these among its younger and more active members, attendance on the extramural program is only twenty per cent below that of an average year in peacetime, while that on the intramural courses has increased approximately twenty-five per cent.

The MSMS granted sixty-six certificates of Fellowship in Postgraduate Education and seventy-two certificates of Associate Fellowship to Michigan physicians at the annual meeting in September, 1944.

In February, 1944, the Secretary of the Society requested suggestions from the committee for a "Postwar Program" designed especially to meet the needs of our members returning from the National Service. Your committee made three specific recommendations: (1) that the framework of the present postgraduate program be continued for the immediate future; (2) that encouragement be given to the enlargement of the present educational programs within the hospitals of this state to permit their carrying on, with the co-operation of the medical schools, postgraduate instruction and direction for those who wish to qualify for specialties after the war; (3) that the tremendous quantity of teaching materials at Eloise Hospital be made available to the faculties of the two Michigan medical schools for the teaching of postgraduate and graduate medicine.

Two committees were requested and these were authorized by the Council. One committee, as indicated in the *second* recommendation above, is under the chairmanship of Dr. Burton R. Corbus, and the other, to explore the possibilities of the *third* recommendation, under Dr. T. K. Gruber. While your committee has no knowledge of details, the Council is to be congratulated in its planning for the medical veteran as evidenced by the report in the JOURNAL, Volume 44, No. 1, page 6, January, 1945, and the subsequent News Letters to the profession.

The Council's program of adequate assistance to our medical veterans in "(a) postgraduate work, (b) relocation, and (c) finances" under the direction of a competent full-time counselor will have the universal approval of our members and the appreciation of the returning veterans.

This report would not be complete without reference to the establishment of the Michigan Endowment Plan which is under another committee assignment. It is now some fifteen years since this idea came under consideration and those of us who have made the quality of medical service our principal interest in the affairs of the medical profession feel a deep sense of satisfaction in the assurance which the completion of this plan gives of a continuance of these activities which have come to be known as the Michigan plan for postgraduate medical education.

Respectfully submitted,
 JAMES D. BRUCE, M.D., *Chairman*
 H. H. CUMMINGS, M.D.
 C. F. BRUNK, M.D.
 CHARLES P. DRURY, M.D.
 W. B. FILLINGER, M.D.
 A. C. FURSTENBERG, M.D.
 C. L. HESS, M.D.
 L. W. HULL, M.D.
 EDGAR H. NORRIS, M.D.
 R. H. PINO, M.D.
 J. M. ROBB, M.D.
 WM. R. TORGERSON, M.D.
 J. J. WALCH, M.D.

COMMITTEE REPORTS

ANNUAL REPORT OF COMMITTEE ON TUBERCULOSIS CONTROL, 1944-45

1. At the request of the Commissioner of Health your chairman designated Dr. John Littig of Kalamazoo and Dr. W. L. Howard of Battle Creek to represent the Tuberculosis Control Committee at a group to meet in Dr. DeKleine's office to discuss adequate diet for tuberculosis patients.

2. Your chairman was appointed last summer by the President of the MSMS to an advisory committee to the Michigan Department of Health considering recommendations to the State Planning Commission. This advisory committee joined in the recommendations of the State Sanatorium Commission to erect a state sanatorium at Houghton and a state sanatorium in southwestern Michigan as well as the eventual abandonment of the present state sanatorium at Oshtemo. These recommendations now seem to be matters of postwar planning.

3. Many of the members of this Committee on Tuberculosis Control were also members of a Legislative Study Committee of the Michigan Tuberculosis Association. The chairman of this committee was Judge Herman Dehnke who, with Dr. George Sherman, worked out House Bill No. 176 which has been passed with minor amendments. This bill seems to have accomplished removal of the care of the tuberculous from the Welfare Agencies. It provides state care for veterans and others without county settlement. It raises the state subsidy to the counties.

4. At the last meeting of the MSMS in Grand Rapids, Dr. Herman E. Hilleboe, Director of the Tuberculosis Division of the USPH Service emphasized that x-ray of all hospital admissions, if done on a national basis, would reach fifteen to thirty million persons annually. He pointed out that this was our most direct and least costly attack on the problem of case finding. At least one hospital in the state has been practicing this since 1941 and finds it both workable and extremely helpful. The Bureau of Tuberculosis Control had in its budget x-ray outfits for miniature x-rays in one hospital in Lansing with the hospital staff backing the venture. One hospital in Detroit is equipped for this work but it is not yet in operation. One hospital in Flint attempted this type of examination but failed to continue.

On June 13, 1945, the Executive Committee of The Council, MSMS, approved this program, provided the project is not instituted in a county unless first approved by the county medical society. It has been suggested that it might be a major function of this committee to promote the extension of this work in Michigan through education and other means.

5. (a) X-ray surveys of small industrial plants have been largely handled in this state by the Bureau of Tuberculosis Control. Your chairman has a letter from Dr. Sherman suggesting that this committee might consider one of the difficulties which Dr. Sherman has encountered. Dr. Sherman has followed a policy of having the x-rays studied by a group consisting of himself, the roentgenologist nearest the plants concerned, the sanatorium director nearest the plants surveyed, and the local health officer. These surveys are always preceded by the approval of the County Medical Society. In spite of that, and the pooling of opinion on the individual x-rays, some tuberculous workers who are advised to enter sanatoria now get contrary advice either from the plant physician, a private physician, and in some cases osteopaths, or from another roentgenologist.

(b) It is reported that plant physicians are sometimes placed in an embarrassing position by management. The lay press has taught management that the only thing needed to discover tuberculosis is an x-ray machine. Management buys the machine and cannot understand why the plant physician might need help in interpreting

the x-rays. A joint committee of the National Tuberculosis Association and American Trudeau Society on Tuberculosis in Industry under Dr. Leroy Gardner has issued a report on the danger of x-ray survey in industry without expert help. Our committee will consider this problem further.

6. In the report of our committee last year and the year before, we brought attention to the difficult problem of evaluating the apparently healthy person discovered in an x-ray survey to have pulmonary tuberculosis. Consultation with a specialist was urged. This was published in the state journal and apparently had little effect. It was suggested at the meeting of the Preventive Medicine Committee that for proper consideration of this item, this committee should meet jointly with Dr. Markuson's Committee on Industrial Health and with the executive committee or representatives of the Michigan Association of Industrial Physicians and Surgeons, the Detroit Roentgen Ray and Radium Society and the Michigan Association of Roentgenologists. It was thought that if these groups could issue a joint statement it might help in the solution of these problems.

Respectfully submitted,

JOHN B. BARNWELL, M.D., *Chairman*

JOS. L. EGGLE, M.D.

L. E. HOLLY, M.D.

W. L. HOWARD, M.D.

W. B. HOWES, M.D.

H. G. HUNTINGTON, M.D.

VINCENT C. JOHNSON, M.D.

JOHN D. LITTIG, M.D.

E. J. O'BRIEN, M.D.

JOHN W. TOWEY, M.D.

ANNUAL REPORT OF THE IODIZED SALT COMMITTEE, 1944-45

I feel very humble in attempting a report for the committee. Any communication should be an eulogy to the work and accomplishments of the only two chairmen, the late Dr. D. M. Cowie and the late Dr. Frederick B. Miner.

Both of these men saw the need of iodine in the prevention of the so common adolescent goiter; both worked unflinchingly with the zeal of a patriot; both saw the efforts of their labor bear fruit in the almost complete disappearance of simple goiter in the adolescent; both stimulated research in the marketing problem of iodized salt. After the passing of Dr. Cowie, Dr. Miner carried on alone. True, he had a committee but it was his own energy and perseverance that successfully fought off the efforts of bureaucratic government to undo all that had been done.

While we can reverently say to each of these men, "Well done, thou good and faithful citizen," we must keep an eternal vigilance that their work may live.

Respectfully submitted,

FRANK VAN SCHOICK, M.D.

ANNUAL REPORT OF MENTAL HYGIENE COMMITTEE, 1944-45

Only one committee meeting was held during the fiscal year of 1944-45. This meeting was attended by all members of the committee.

The State Mental Hygiene program proposed by Governor Kelly was carefully evaluated and a report submitted to the Executive Committee of the Council of the Michigan State Medical Society. The consensus of opinion of those present was that the mental health problem of the state resolved itself into two departments: the department of hygiene, and the department of treatment. The department of treatment represented by the state hospitals is being administered at the present time in a very efficient and successful manner; in fact, Michigan is one of the outstanding states in the Union in hospital administration and treatment.

COMMITTEE REPORTS

A Mental Health Director should direct his activities to the field of preventive medicine and act only as a counsellor to the hospital superintendents.

A communication was sent to the Council of the Michigan State Medical Society requesting more attention to the subject of Neuropsychiatry at the next annual session of the Society.

Respectfully submitted,

H. A. LUCE, M.D., *Chairman*
R. G. BRAIN, M.D.
M. H. HOFFMANN, M.D.
R. A. MORTER, M.D.
H. A. REYE, M.D.
R. W. WAGGONER, M.D.
O. R. YODER, M.D.

ANNUAL REPORT OF PRELICENSURE MEDICAL EDUCATION COMMITTEE, 1944-45

The membership of this Committee is desirous of accomplishing its important purpose; however, the Committee is unable to function under the 9-9-9 Program inasmuch as the Army and Navy have their own rules which have been temporarily indorsed as a War Measure.

It is our recommendation that the Committee be continued as a standing committee in order that it may function as soon as it has the opportunity.

Respectfully submitted,

J. EARL MCINTYRE, M.D., *Chairman*
DONALD C. BEAVER, M.D.
GEORGE J. CURRY, M.D.
A. C. FURSTENBERG, M.D.
EDGAR H. NORRIS, M.D.
F. J. O'DONNELL, M.D.

ANNUAL REPORT OF MATERNAL HEALTH COMMITTEE, 1944-45

The Maternal Health Committee during the past year has contemplated carefully the maternal mortality study program planned for future initiation. The study blanks prepared for this purpose have been reviewed and worked into better shape.

While it was originally planned to make this a contemporary study the Foundation which was to finance the program decided that the time was inopportune so it has been necessary to postpone the whole program until after the war.

Respectfully submitted,

C. E. TOSHACH, M. D., *Chairman*
A. E. CATHERWOOD, M.D.
HAROLD HENDERSON, M.D.
WM. G. HOEBEKE, M.D.
EDWARD D. KING, M.D.
N. F. MILLER, M.D.
A. M. CAMPBELL, M.D.

ANNUAL REPORT OF PUBLIC RELATIONS COMMITTEE, 1944-45

The individual members of the Public Relations Committee have contacted and addressed county medical societies in their districts, as well as lay groups, during the past year.

The greatest promotional work of the Public Relations Committee was achieved by its Advisory Committee on Radio composed of C. L. Candler, M.D., President A. S. Brunk, M.D., and Speaker P. L. Ledwidge, M.D. The monumental accomplishments of

this Special Committee on Radio is outlined in its own Annual Report.

The Public Relations Committee anticipates that the ensuing year will be an active one, and that it will bring forth a program of medical public relations the like and size of which has not been attempted by any other state medical society in the Union.

Respectfully submitted,

FRED R. REED, M.D., *Chairman*
C. L. CANDLER, M.D.
C. G. CLIPPERT, M.D.
JOHN S. DETAR, M.D.
NATHAN J. FRENN, M.D.
L. T. HENDERSON, M.D.
W. J. HERRINGTON, M.D.
S. W. INSLEY, M.D.
JOHN J. MCCANN, M.D.
HOMER A. RAMSDELL, M.D.

ANNUAL REPORT OF COMMITTEE ON PROCUREMENT AND ASSIGNMENT SERVICE FOR DOCTORS OF MEDICINE, 1944-45

The State Chairman of Procurement and Assignment Service has been supplying the Navy with doctors who were declared available by the County P. & A. Committees. The number of doctors who could be spared was not sufficient, and the Surgeon General sent a directive giving the Navy first choice of the returning Army doctors to meet its needs. To date the quota has not been met. Second choice had been given to the Veterans Bureau Facility and many doctors were assigned to this duty. Recently, a directive was released stating that all those returning doctors assigned to the Veterans Bureau will be on a voluntary basis. All officers who had formerly worked in the Veterans Bureau will be assigned to the Veterans Bureau Facility.

The returning doctors are now needed in their home communities. According to the last directive, requests for release were to be sent to the Appeal Board in Washington, D. C., and if approved, the papers were sent to the officer who handed his resignation to his Commanding Officer. If approved by the Commanding Officer, the papers were forwarded through military channels to the Surgeon General. This has not been effective, and so far no one has been released.

Until the needs of the Navy and the needs of the Army in the Pacific are well established, few will be returned. The last procedure is explained in the following paragraph by George F. Lull, M.C., Major General, USA, Deputy Surgeon General: quote

"I wish to inform you that with the announcement of the War Department's overall policy to release officers, the selection of such officers will be determined by their adjusted service rating scores, the desire of each officer as to his retention in the service, efficiency and *military necessity*. It will be necessary for individual officers to be compared with other Medical Corps officers who have been in the military service since 16 September 1940, in order to determine their essentiality to the Army in the continuation of hostilities with Japan. This method of determination will allow an equitable relief from active duty of officers on the basis of their age, length and type of service, in addition to dependents."

Respectfully submitted,

P. R. URMSTON, M.D., *Chairman*
F. G. BUESSER, M.D.
WARREN B. COOKSEY, M.D.
MILTON A. DARLING, M.D.
L. A. FARNHAM, M.D.
L. FERNALD FOSTER, M.D.
C. D. MOLL, M.D.
C. I. OWEN, M.D.
H. H. RIECKER, M.D.

COMMITTEE REPORTS

ANNUAL REPORT OF VICE CHAIRMAN, COMMITTEE ON PROCUREMENT AND ASSIGNMENT SERVICE, 1944-45

(Counties of Wayne, Washtenaw, Oakland,
Monroe, Macomb)

During the past few months Procurement and Assignment has been especially concerned with efforts to augment the Medical Service of the Navy, the Army having indicated they would not commission any additional physicians from civilian life.

In spite of the large number of Doctors who have gone into Service in the above areas, medical service has

been sustained on a relatively high plane. The number of Doctors who have returned from Service has been comparatively few and it is not anticipated this number will increase materially in the near future.

I take this opportunity to thank the members of the local committees in the areas involved for their co-operation, without which, obviously, this work could not have been done.

I also wish to thank the Wayne County Medical Society for its generosity in providing us with space in the Medical Society building in which to carry on this work for Procurement and Assignment Service.

Very truly yours

CLARENCE D. MOLL, M.D., *Vice Chairman*

MSMS ROSTER—SUPPLEMENTAL LIST

Bay County

Ely, Nina Bay City

Genesee County

Gutow, I. Flint
Lavin, Kathryn Flint
McGarry, Roy A. Flint
Wright, George R. Montrose

Grand Traverse- Leelanau- Benzie

Baker, Dorothy M. Traverse City

Kent County

Graybiel, George P. Caledonia
Osborn, Howard Grand Rapids
Stuart, G. J. Grand Rapids
Thompson, Athol Grand Rapids

Macomb County

Allen, L. K. Roseville

Med. Soc. North Central Counties

Martzowka, M. A. Roscommon

Oakland County

Mershon, R. B. Royal Oak

Tuscola County

Von Renner, Otto Vassar
Morris, F. L. Cass City
Berman, Harry Millington
Cook, Raymond Akron
Ruskin, David B. Caro

Wayne County

Balaga, Frank T. Detroit
Berkman, Ruth Detroit
Berry, Joseph E. Detroit
Bittrich, Norbert Detroit
Boland, John R. Detroit
Brain, R. S. Detroit
Broderson, Harvey S. River Rouge
Burns, Robert T. Detroit
Cleage, Louis J. Detroit
Crawford, Albert S. Detroit
Demaray, John F. Detroit
Dubin, Joseph J. Detroit
Freedman, Milton Detroit
Galvin, Paul P. Detroit
Graham, Julius A. Detroit

Grant, Heman E. Detroit
Gardner, Lawrence Detroit
Harmon, Walter Detroit
Harris, Albert E. Detroit
Hendy, H. W. Detroit
Isaacs, Joseph C. Detroit
Jordan, R. Gerald Detroit
Keim, Harther L. Detroit
Kleinman, S. Detroit
Lalime, George Detroit
Larsson, B. Detroit
Lewin, Harry Detroit
Mayer, E. V. Highland Park
McDougall, Bernard Detroit
Morin, John B. Detroit
Myers, Gordon B. Detroit
Millard, Glenn E. Detroit
O'Connell, Wm. J. Detroit
Rieden, James A. Detroit
Robertson, Stanley B. Detroit
Robertson, Tom H. Detroit
Roseman, J. D. Detroit
Sanderson, Jos. L. Detroit
Shellhamer, Claire S. Detroit
Steiner, E. A. Detroit
Stocker, Harry Detroit
Thorstad, Merrill J. Detroit
Yesayan, H. G. Detroit
Zielinski, Charles J. Detroit

LOW BACK PAIN IN MANY INSTANCES MAY BE CAUSED BY FAT HERNIAS

Functional back pain—considered to be of mental origin in many cases—may be due to hernias of fatty tissue, reports Ralph Herz, M.D., of Cleveland, in *The Journal of the American Medical Association* for July 28.

Dr. Herz explains that there is a continuous sheet of connective tissue, like that which forms in a scar, which lies under the outer skin layer and covers the entire back from neck to below the waistline. There is little or no fat between this and the deep connective tissue in normal individuals, with the exception of a few spots where fat deposits do occur to make up the basic fat pattern. In fat persons, however, this pattern is obscured by a generalized distribution of fat. The tissue is not of uniform thickness, and where it is noticeably thinner, these small fat hernias tend to break through.

Such a hernia may not give rise to symptoms until some incident, such as sudden injury or an illness, confines the patient to bed. The several days which are spent lying in bed produce an increase in pressure on the fat, causing pain. This leads to swelling, which may make the condition permanent.

The pain generally begins at a central point, from which generalized pain is directed or referred to other

areas. This referred pain may occur at a distance from the source, as in many cases of sciatica. Dr. Herz points out that "important diagnostic features are the severity of the pain, the frequency of radiating pain down the leg, and the presence of a palpable tender mass (easily discovered by touch), which is a 'trigger point' of the pain, which can be relieved temporarily by injection with anesthetic solution."

The author reports on six cases which were relieved by surgery. He states that the cutting away of fatty tissue in the painful area afforded "complete and immediate relief from the back pain."

In conclusion, he says: "It seems probable that some patients (perhaps a fairly large proportion) in whom the cause of back pain has not been diagnosed previously may have herniations of fat and that surgical removal of these will bring prompt and lasting relief. This operation is not presented as a panacea for all types of low back pain. However, it seems certain that if the possibility of such a lesion (injury) is recognized and if careful examination is made for palpable masses which may prove to be trigger points of pain, numerous patients may by this procedure be relieved of a condition that has been incapacitating, sometimes for many years."

Woman's Auxiliary

LEGISLATIVE WORK

The Auxiliary Legislative chairman has worked very closely with the efficient Legislative Committee of the Michigan State Medical Society during the past year regarding medical legislation. A report on the MSMS legislative activity appears elsewhere in this JOURNAL.

I wish to express my appreciation to the members of the Woman's Auxiliary, to our State President, Mrs. H. L. French, and to all our friends who have kept our representatives in the Senate and House informed regarding our views.

(MRS. SHERMAN E.) JOSEPHINE MANNING ANDREWS
State Chairman, Committee on Legislation

* * *

HYGEIA

This year we have tried to make each Auxiliary member conscious of the responsibility that she must accept in order to make this *Hygeia* contest the success that it should be in our state.

We have had a most generous response, and I am very grateful.

I am proud to report that St. Joseph County won first place in Group II and Wayne County won honorable mention.

We had fourteen of the twenty active auxiliaries participating with 699.5 subscriptions, which was almost 50 per cent over last year, and I hope that next year will bring the much greater increase that we should obtain.

MRS. D. M. KANE
State Chairman

* * *

BAY COUNTY

The Woman's Auxiliary to the Bay County Medical Society had its final meeting for this spring, Wednesday, May 9, at the home of Dr. and Mrs. A. D. Allen.

This meeting was a joint dinner meeting with the Medical Society. Sixty were present.

The April meeting was held at the home of Mrs. J. Norris Asline, April 11. There were twenty-seven present.

Mrs. H. L. French, State president of the Medical Auxiliary, was our guest and gave an interesting talk outlining the state and national program. Mrs. C. L. Hess, president, conducted a short business meeting. Mrs. Robert B. Hall gave a book review *Martha Washington*.

* * *

GENESEE COUNTY

The *Bulletin*, official publication of the Genesee County Medical Society, published a Woman's Auxiliary issue on April 10. It contains the history of the Woman's Auxiliary of the Genesee County Medical Society—annual reports of officers and committee chairmen, and auxiliary news notes. Following is a copy of The Auxiliary President's Report:

Seven regular meetings were held during the year, to March, 1945, with an average attendance of twenty members. Four were luncheon meetings and three were teas. Mrs. Bogart very kindly opened her home to us and twice during that year the hospitality of Hurley Nurses home was extended to us. Three luncheons were held at the Milner and one at the Durant.

At the April and May meetings a report was given on the Cancer Fund drive, many of our members contributing time at the various booths, and a cash donation was made by the Auxiliary. Games and cards were contributed and sent to the USO stations in Alaska. Contributions to both Girl Scout and Girl Reserve Camp Funds were voted. Following the May meeting the Auxiliary recessed for the summer months to resume regular meetings in October, after the state convention in Grand Rapids when reports of the National convention in Chicago and the State convention in Grand Rapids were read. It was our privilege at this time to have Frank E. Reeder, M.D., of the State Advisory Committee and Mr. W. W. Blackney, U. S. Representative from this district, as our guests. Both spoke on the social trends in medicine.

In January, Mrs. H. L. French, State President, was guest of the Auxiliary, speaking on aims and projects of State and National organizations. A committee was appointed to draw up the slate of officers to be presented in February and voted on in March. The February meeting was a tea at the Nurses' Home, with Miss McNeal presenting the Cadet Nursing Project, and a program of music and reading was given.

The year was concluded with the Annual Meeting and election of officers in March at which time Mrs. R. B. Macduff succeeded to the chair. Major G. Willoughby spoke on his experiences in the European Theatre of War.

During the year my officers, chairmen and committee workers have been most helpful and faithful and I gratefully acknowledge their co-operation, and tender my sincere thanks to each and every one.

May I extend to the succeeding president, Mrs. Macduff, a most hearty welcome and wish her a most successful year.

* BERNICE R. WRIGHT, *President*

* * *

SAGINAW COUNTY

Three Red Cross meetings (surgical dressings) were held, two in November, 1944, and one in March, 1945.

In December, 1944, six Auxiliary members sponsored an educational program for the Saginaw Reading Club. Short talks were given by some of these members on Recent Medical Progress. "The Story of Blood Plasma," a talkie in technicolor, was also given. This film was produced by Sharp and Dohme Pharma-

(Continued on Page 848)

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WOMAN'S AUXILIARY

(Continued from Page 846)

ceutical Company. Over two hundred people were present at this meeting.

In January one of our own members, Mrs. E. H. Stahly, gave an illustrated lecture on her personal experiences in India.

In February the Auxiliary members sponsored a benefit card party at Anderson Hall, Saginaw General Hospital's new Nurses' Home. About two hundred fifty people attended. Proceeds from the party amounting to \$250 will be used to purchase recreational equipment for the Hall.

At the April meeting Dr. Norman C. Westlund, Director of the Saginaw Valley Children's Center, discussed "The Mental and Moral Growth of Children." At the business session a ten dollar contribution was made to the Saginaw Unit of the American Cancer Society.

* * *

NEWAYGO COUNTY

On March 2 Newaygo Auxiliary celebrated the seventieth birthday of their oldest member, Mrs. Charles Black of Holton, by surprising her with a large birthday cake and flowers.

On April 24 a pot-luck dinner was held at the home of Mrs. Ted Deur of Grant and included the four dentists' wives of the County.

* * *

MANISTEE COUNTY

On February 23 a joint meeting with the County Medical Society was held. Mrs. Homer S. Ramsdell reported on work done and contacts made with professional men, labor unions, druggists, and clubs on proposed revision to constitution of State of Michigan. The importance of co-operation of the Medical Society in the April drive for the Field Army of American Cancer Society was stressed. The Auxiliary has made 1,000 dressings for county use and has sent 1,000 to State Headquarters.

A joint meeting of Grand Traverse, Wexford, Missaukee and Osceola counties was held on May 18. It was in the form of a picnic supper at Dr. and Mrs. Ramsdell's home with Manistee Auxiliary hostesses.

EVACUATION OF ETO PATIENTS

More than 100,000 sick and wounded soldiers have been returned from Europe since V-E Day, according to Brigadier General Raymond W. Bliss, Assistant Surgeon General of the Army.

The Army set for itself a goal of returning by plane and ship all transportable wounded from Europe within ninety days after V-E Day, and the record job was completed before the August 8 deadline. In the last war thousands of wounded awaited transportation from Europe for a year.

The number of non-transportable cases is comparatively small, General Bliss pointed out, and these will be transported to the United States as they are able to be moved.

JOUR. MSMS

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Correspondence

Paul C. Barton, M.D.
Procurement & Assignment Service
1778 Pennsylvania Ave., N.W.
Washington 25, D. C.

Dear Dr. Barton:

A clipping from one of the Chicago papers was sent to me yesterday quoting "Major General George F. Lull, deputy surgeon of the Army, announced from Washington, D. C., yesterday that under a new program just invoked by the War Department medical officers released from service henceforth are to be given the privilege of electing whether they wish to accept continuing assignments with the veterans' administration in this country."

Please confirm this report, as it will be a great satisfaction to the medical profession at home as well as to those officers who are returning to this country from foreign service.

Yours respectfully,
P. R. URMSTON, M.D.
Procurement & Assignment
Service

Michigan Consultant
War Manpower Commission

June 15, 1945

Paul R. Urmston, M.D.
916 Washington St.
Bay City, Michigan

Dear Doctor Urmston:

This will acknowledge your letter of June 15 concerning the statement on the front page of the Chicago *Tribune* and contributed by Maj. Gen. George F. Lull. This statement, so far as I know, was based on an official release by the Army, and the facts stated therein correctly reported by the *Tribune*. There may be a few technicalities in connection with this proposal, but I believe that at an early date there will be no further question of any Army officer being assigned to the Veterans' Administration except at his specific request.

Sincerely yours,
PAUL C. BARTON, M.D.
Executive Officer
Procurement & Assignment
Service, Washington, D. C.

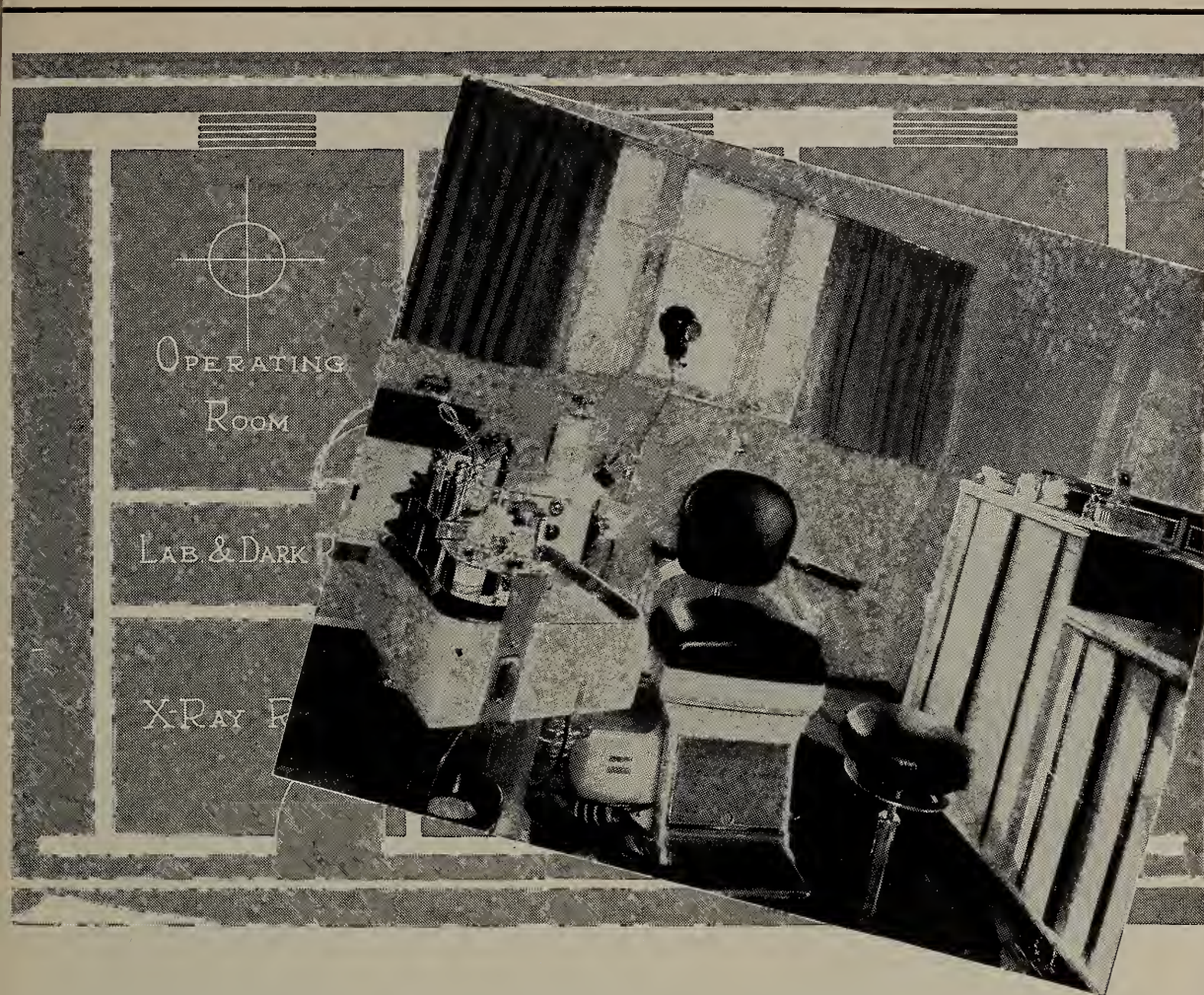
June 20, 1945

June 25, 1945

Wilfrid Haughey, M.D.
610 Post Bldg.
Battle Creek Michigan,
To the Editor (JOURNAL, MICHIGAN STATE MEDICAL
SOCIETY):

In the May issue of THE JOURNAL you published an article entitled "GI Bill and Medical Veterans" which
(Continued on Page 852)

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CORRESPONDENCE

(Continued from Page 850)

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stated that "under the GI Bill they (medical veterans) are entitled to a one-year refresher course in any professional school in the United States." By inference one would assume that medical veterans could obtain refresher courses of short duration at Government expense. Such is not the case. The Veterans' Administration has dealt the service doctors a joker in that regard. They have ruled that for courses of less than thirty (30) weeks they will pay only a proportion of the tuition fee.

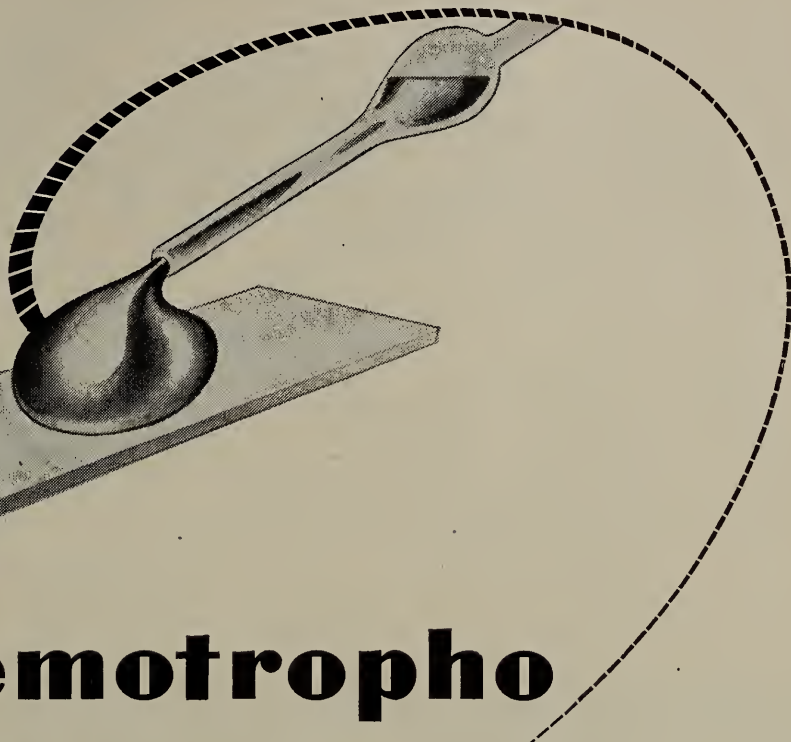
I have a letter dated February 24, 1945, signed by H. V. Stirling, Director Vocational Rehabilitation and Education Service, Veterans' Administration, Washington, D. C., from which I quote in part. "An ordinary school year has been interpreted to mean a school year of two semesters or three quarters or the equivalent (not less than thirty nor more than thirty-eight weeks). For a course of education or training which is set up for a period of time less than an ordinary school year, the Veterans' Administration may pay only that amount which bears the same relation to \$500 as the length of the course bears to an ordinary school year."

Obviously few doctors now in service can afford to take a year of postgraduate training with no more financial backing than the government-furnished subsistence allowance of only \$50 or \$75 per month. After spending three to five years in service on greatly reduced pay, most service doctors will be without financial reserves. Therefore, they will have to return to private practice very soon after release from active duty. They will want short refresher courses of from two to six or eight weeks' duration. I believe that surveys recently conducted indicate as much. If the medical veteran takes a short intensive course of say two weeks for which the tuition fee is \$200, he can expect the government to pay only one-fifteenth of \$500 toward that tuition, namely \$33.33. This is small help indeed to those whose services have made it possible for our government to boast that our Army receives the best medical care in the world!

Here is an injustice to medical veterans that our State Postwar Planning Committee could do much to correct. If our State Society would represent the cause of our 2,000 service doctors by presenting to Michigan congressmen cogent reasons why this phase of the GI Bill, Public No. 346, 78th Congress, should be amended, the Society would be doing something constructive to redeem its pledge made to the doctors in the services last January.

JOHN G. SLEVIN, M.D.
(Colonel, MC, Inactive).

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What's What

Honors

Sir Alexander Fleming, the eminent British physician who discovered penicillin, was honored by the Wayne County Medical Society at a reception in the David Whitney House, June 14. Following his introduction by President Stanley W. Insley, M.D., and by A. W. Lescohier, M.D., of Parke, Davis & Co., Dr. Fleming related some of the interesting details of his early research and generously participated in an informal question and answer period.

* * *

Major William E. Clark, M.C. (formerly of Mason) has received two decorations for outstanding service. The Bronze Star was awarded for service beyond the call of duty in France and Belgium, and more recently the Oak Leaf Cluster was awarded for the same kind of service in Luxembourg and Germany.

* * *

Captain R. H. McArthur, Jr., M.C. (formerly of Flint) was awarded the Soldier's Medal for heroism. Dr. McArthur saved the life of a pilot of a fighter aircraft whose plane had caught fire and was filled with bombs.

* * *

Charles F. McKhann, M.D., Detroit, has been named Professor of Pediatrics at Western Reserve University

School of Medicine and Director of Pediatrics at University Hospital, Cleveland. Dr. McKhann has for the two past years been Assistant to the President in charge of research at Parke, Davis & Co., Detroit.

* * *

The following Michigan men were recently elected Fellows of the International College of Surgeons: W. W. Babcock, M.D., W. J. Cassidy, M.D., B. F. Glowacki, M.D., W. E. Johnston, M. D., E. G. Martin, M. D., C. C. McCormick, M. D. and E. J. Panzner, M.D., all of Detroit; Thomas Wilensky, M.D., Lansing; Associates: Major Frederick N. Hanson, M.C. and Carl S. Ratigan, M.D., both of Dearborn and T. O. Stewart, M.D., of Detroit; Matriculates: S. J. Shanoski, M.D., and N. L. Schmitt, M.D., Detroit.

* * *

Capt. Stanley Lowe, M.C., of Battle Creek, has received the Bronze Star for heroic service caring for wounded soldiers under direct fire, during the Remargin Bridge crossing of the Rhine.

* * *

The following promotions have been announced by the Surgeon General's office: Lowell Byron Ashley, MC, Detroit, to Colonel; Howard Bostwick Hoffman, MC, Ludington, to Lieutenant Colonel; Grant Lyman

(Continued on Page 856)

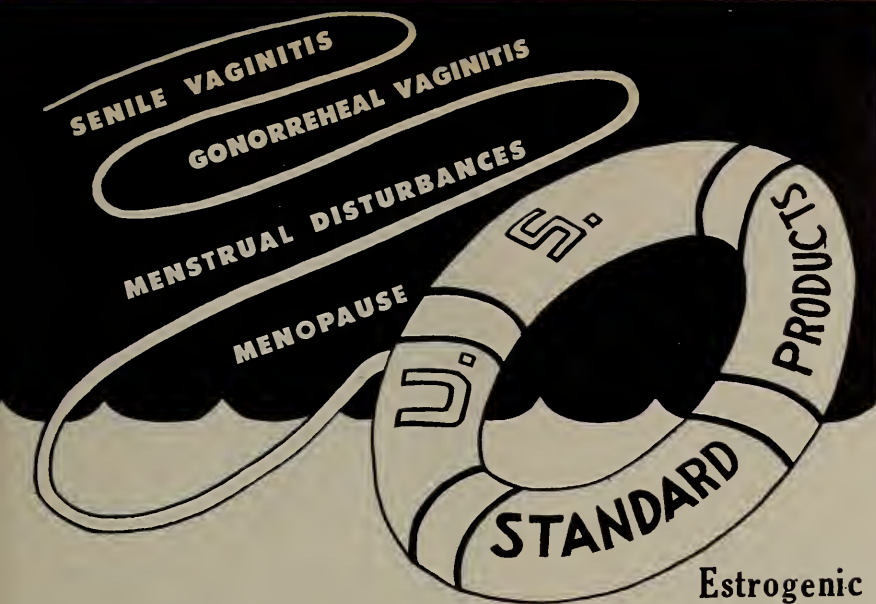
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WHAT'S WHAT

(Continued from Page 854)

Otis, MC, Jackson, to Lieutenant Colonel; Winston Robert Wreggit, MC, Highland Park, to Lieutenant Colonel; Robert Simpson, MC, Battle Creek, to Major.

* * *

In Congress

The U. S. Children's Bureau has received from Congress an appropriation for 1946-47 of \$56,365,510, as compared with \$55,095,400 for the previous fiscal year. Of this amount, \$44,189,500 is for the EMIC Program for twelve months, beginning July 1, 1945. The original EMIC appropriation just a few years ago was \$1,200,000!

* * *

A bill has been introduced in Congress to provide for the payment of a gratuity to the parents of children hereafter born. S. 837 (Senator Langer of North Dakota) would pay to the parents of each child born after the date of enactment of the act the sum of (a) \$500 if such parents are the parents of one other child; (b) \$750 if such parents are the parents of two other children; and (c) \$1,000 if such parents are the parents of three or more other children!

* * *

Congressman McDonough of California has introduced a bill into the U. S. House of Representatives to authorize the release of persons from active military service and the deferment of persons from military service, in order to aid in making possible the education and training and utilization of scientific and technological manpower to meet essential needs both in war and in peace (H.R. 2827).

Among those to be deferred are "15,000 trained scientists and engineers now employed in research or by industry in work essential to the health, safety, and welfare of the nation."

* * *

Meetings

The Fifth International Assembly (tenth anniversary of the founding) of the International College of Surgeons will be celebrated in Lima, Peru, September 10-11-12, 1945, under the sponsorship of the Peruvian Government.

* * *

Council and Committee meetings.

1. Committee on Public Relations and Radio for Seventeen States, Statler Hotel, Buffalo, N. Y., May 24.
2. Special Committee on Radio, Detroit, June 1.
3. Special Committee on Radio, Detroit, June 4.
4. Executive Committee of The Council, Book-Cadillac Hotel, Detroit, June 13.
5. Liaison Committee with University of Michigan President, Michigan Union, Ann Arbor, June 21.
6. Special Committee on Radio, Station WJR, Detroit, July 6.

(Continued on Page 858)

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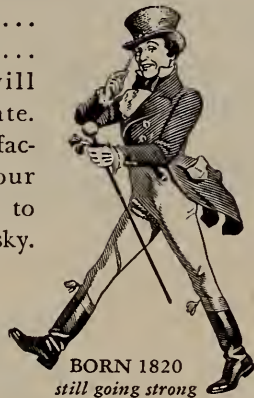
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WHAT'S WHAT

(Continued from Page 856)

7. Rheumatic Fever Control Committee, Mackinac Island, July 12.
8. The Council, Mackinac Island, July 13-14.
9. Publication Committee of The Council, Mackinac Island, July 13.
10. Liaison Committee with Insurance Association Detroit, July 25.

* * *

The American Congress of Physical Medicine has cancelled its 1945 session scheduled for New York City September 5 to 8, 1945.

* * *

A Tip

"Public Relations begins at Home"—Joseph S. Lawrence, M.D., Washington, D. C.

* * *

Good Reading

The Detroit Medical News, in its June 25 number presented an informative article on "Maximum Weekly Allowance on Rationed Foods for Special Diets." Official information on rationing, together with a list of diseases and ailments for which additional rationed foods have been requested at local ration boards, were included in the article.

* * *

John W. Hirshfield, M.D., William E. Abbott, M.D., Matthew A. Pilling, M.D., and C. W. Buggs, Ph.D. Detroit, are authors of an article "Penicillin in Treatment of Empyema" which appeared in JAMA of June 23, 1945.

* * *

C. D. Selby, M.D., Detroit, is the author of an original article "X-Ray Examinations of Chest" which appeared in JAMA of June 30.

L. E. Himler, M.D., Detroit, is the author of "Psychiatric Technics" which appeared in JAMA of June 30.

* * *

Marvin Schwartz, M.D., and Elmore C. Vonde Heide, M.D., Detroit, are authors of "Thrombocytopenic Purpura" which appeared in the June 30 JAMA.

* * *

Miscellaneous

Vacancy for male or female doctor as House Officer, International Grenfell Association Hospital, St. Anthony, Newfoundland. Hospital has eighty beds with two auxiliary annexes of twenty beds each. This organization provides the only medical care for North Newfoundland, and the position offers unique and valuable experience.

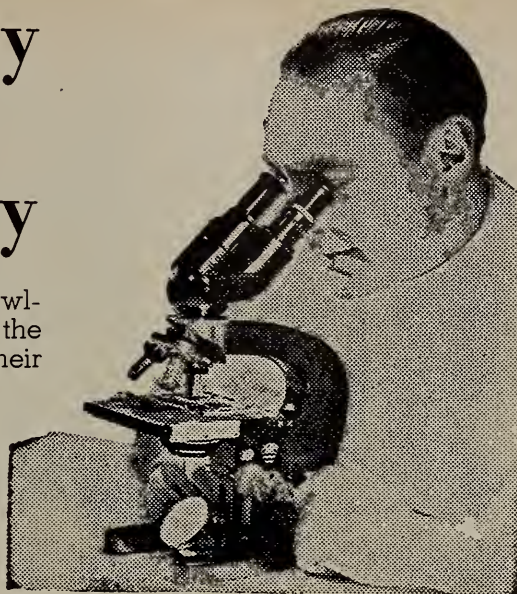
Vacancy occurs in August, or as soon after as possible, for one year. Full maintenance, including family accommodation, and travel, provided. Salary dependent on experience—\$2,500 for a well-qualified candidate.

(Continued on Page 860)

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WHAT'S WHAT

(Continued from Page 858)

Apply Staff Selection Committee, International Grenfell Association, 156 Fifth Avenue, New York 10, N. Y.

* * *

The Michigan State Board of Registration in Medicine has given official notice of the revocation of the medical licenses of David Friedman, M.D. of Detroit and of LeRoy Wellstead, M.D. of Ottumwa, Iowa; also the suspension for one year the license of Carl W. Wagar, M.D. of Kalamazoo, as well as the continuation for one year of the suspension of the license of Edward H. Thomas, M.D., Detroit.

* * *

Wayne Medical School Graduates 67 Doctors

The Wayne University College of Medicine graduated its 78th class on Monday, June 25, when sixty-seven graduates received their doctor's degrees from President David D. Henry.

Of the sixty-seven, forty-five are enlisted men in the United States Army, and eleven are in the Navy. Eleven others are civilians, two of them women. The two women are Susan C. Pidgeon, 15394 Ohio, and Jean Ellen Stevenson, 2229 W. Grand Boulevard.

* * *

Policy on Assignment of MC Officers to Veterans' Administration

Additional U. S. Army Medical Corps officers will not be assigned to duty with the Veterans' Administration unless they had previously been serving on the

staff of that organization, Major General George Lull, Deputy Surgeon General of the Army, announced.

In outlining this War Department policy General Lull stated that in the event officers specifically requested service with the Veterans' Administration they would be eligible for such assignments.

* * *

Postwar Jobs in Medical Occupations

Students, teachers, parents and others interested in medical occupations will find helpful information in three new six-page Occupational Abstracts on *Medicine*, *Nursing*, and *Medical Laboratory Technologist*, just published by Occupational Index, Inc., New York University, New York 3, N. Y., at 25 cents each or 75 cents for the three.

Each abstract covers the nature of the work, abilities and preparation required, entrance and advancement requirements, earnings, number and distribution of workers, postwar prospects, advantages and disadvantages and sources of further information, including a select bibliography of the five best references.

* * *

Board Approves Gifts to Wayne

Acceptance of gifts to the Wayne University College of Medicine totaling \$15,657, has been approved by the Board of Education.

Included was a grant of \$7,557 from the Federal Office of Scientific Research and Development to be used for the study of contaminated wounds, protein metabolism.

(Continued on Page 862)

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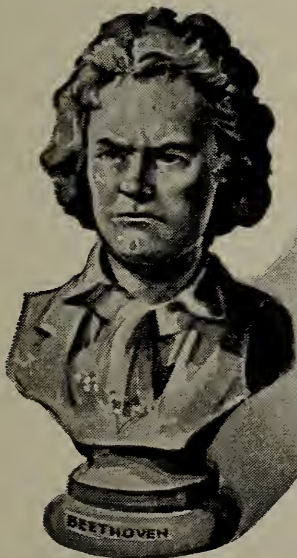
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WHAT'S WHAT

(Continued from Page 860)

lism, and sodium lactate; a gift of \$5,000 from the Griffith Laboratories, Chicago, for a two-year study of anti-oxidants; another of \$2,000 from the Children's Fund of Michigan for continuation of the work on the brain disease registry; a grant of \$1,000 from O. C. Frohnknecht to finance research on multiple sclerosis; and the sum of \$100 from Dr. James D. Bruce, of Ann Arbor, for the continuation of the Theodore A. McGraw Scholarship.

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(Note the hour—6:30 p.m.)

Nancy Rodger Chenoweth, M.D., is the first member of Delta-Schoolcraft County Medical Society to be made "Member Emeritus." She recently completed fifty-one years in practice, over thirty-five in Escanaba. Dr. Chenoweth now plans to dispose of her office and residence and to transfer to Peterborough, Ontario where her son, Rodger Chenoweth, M.D., is Chief Surgeon for the Canadian General Electric Company. A new Civic Hospital is under construction in Peterborough and our Member Emeritus has been asked to take charge of the Geriatrics Section, to which specialty she will devote her entire time.

* * *

The Cummins Optical Company, Detroit, is celebrating its tenth anniversary this year by moving to new quarters covering half of the fourth floor of the Kales Building. Company leadership is vested in Stanley H. Cummins, President, Harold R. Larkins, Vice-President, and General Manager, and William B. Wood, Secretary-Treasurer.

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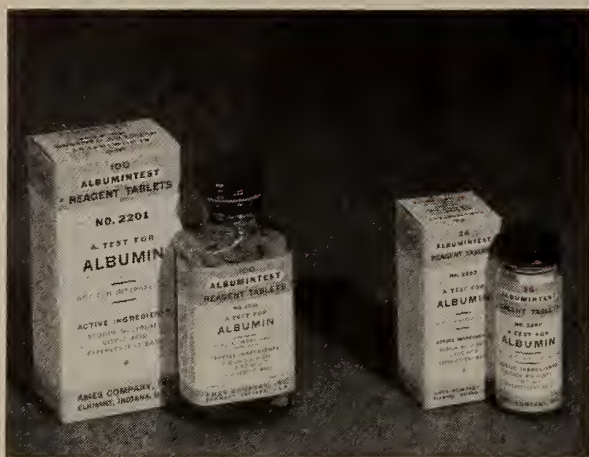
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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

MASS RADIOGRAPHY OF THE CHEST. By Herman E. Hilleboe, M.D., Medical Director, Chief, Tuberculosis Control Division, United States Public Health Service; Professorial Lecturer on Tuberculosis Control. George Washington University School of Medicine, Washington, D. C., and Russell H. Morgan, M.D., Surgeon(R), Medical Officer in Charge. Radiology Section, Tuberculosis Control Division, United States Public Health Service; Assistant Professor of Roentgenology, Absent on Leave, The University of Chicago. Chicago: The Year Book Publishers, Inc. 1945. Price, \$3.50.

It has been years since the discovery that chest films show striking evidence of tuberculosis infection of the chest before the physical findings are detectable. Programs for tuberculosis control soon developed, but the cost was prohibitive. Mass roentgen studies, however, make this method of screening most applicable, especially since the small film may be used. This book gives the history of the procedure, the plans and instruments used, the equipment and technique, all well illustrated, to make its use and understanding available to workers. About half of the book is devoted to the chest diagnosis, and industrial contacts.

TEXTBOOK OF ABNORMAL PSYCHOLOGY. By Roy M. Dorcas, Associate Professor of Psychology, University of California at Los Angeles; and G. Wilson Shaffer, Dean of the College of Arts and Sciences. Lecturer in Psychology, Professor of Health and Physical Education, Johns Hopkins University; Psychologist, Sheppard-Enoch Pratt Hospital, Towson, Maryland. Third Edition. Baltimore: The Williams & Wilkins Company. 1945. Price, \$4.00.

This book is a profound study of the normal and abnormal states of the patient, and has been so popular that the first two editions went through ten printings, in two years. The studies and text are made up for the well-prepared and serious student. Normal conditions are explained in an effort to understand the abnormal. Explanations are full and sufficiently detailed. Sensory and motor disturbances are described, disorders of association and memory, of the central functions, desires, feelings, et cetera, are well described and explained. A goodly section of the book is devoted to desires, dreams, emotions, feelings, et cetera. There is a classification of mental diseases, and a section on psychotherapy. There are 833 references.

THE NEW-BORN INFANT—A Manual of Obstetrical Pediatrics. By Emerson L. Stone, M.D., Associate Clinical Professor of Obstetrics and Gynecology, School of Medicine, Yale University; Attending Obstetrician and Gynecologist to the New Haven Hospital. Third Edition, Thoroughly revised. Philadelphia: Lea & Febiger. 1945. Price, \$3.25.

The new infant is suddenly subjected to tremendous changes in its life and conditions. It is immediately as important a subject as the mother, and demands immediate attention. Death rates have been reduced 53 per cent in the years 1916 to 1934, and all studies now look to further reduction. The book discusses the

(Continued on Page 866)

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(Continued from Page 864)

immediate care of the new-born, then the physiology and development. A complete list of the essential supplies to have on hand is given, and a chapter on the nursing of the infant, care of the nipples, et cetera. Breast feeding is ideal, but fundamental directions are given for modified feedings. Common diseases of the infant, injuries, deformities, infections, are given. The book recognizes the value of the specialties, and boards in encouraging study of conditions leading to better practices, and lessening of mortality rates. A valuable treatise for the obstetrician, and the general practitioner.

THE MALE HORMONE. By Paul de Kruif, New York: Harcourt, Brace and Company. 1945. Price, \$2.50.

As in so many books and articles de Kruif is all enthusiasm about the new topic, testosterone, the male hormone, but this book shows much more research before the writing. He has exhaustively studied the subject, and told the story of hopes, and results. This subject is surely controversial, which seems to be de Kruif's forte, and he has not minced words, calling things by their right names, and clinching his argument with reports from every direction. Whether testosterone will relieve the pseudo coronary, invigorate the older man of affairs who is beginning to falter in his quick judgments, warm the cold feet, or stay the male climac-

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teric, this book should be read by medical men because it certainly will by the laity, and the medical consultant will be asked what about it?

DOCTORS AT WAR. Edited by Morris Fishbein, M.D., Editor of the Journal of the American Medical Association, and of Hygeia; Chief Editor of War Medicine; Chairman of the Committee on Information of the Division of Medical Sciences of the National Research Council; Illustrated with Photographs and Charts. New York: E. P. Dutton & Company, Inc. 1945. Price, \$5.00.

Doctors at War tells authoritatively of the work and preparations for every phase of the doctors' work in this war. The records and accomplishments, the odds, and difficulties are all given by the men most able to tell the story. Drs. Fishbein, George B. Darling, Harold S. Diehl, General Grant, Charles Griffiths, General Hawley, General Kirk, General Lull, Admiral McIntire, Captain Moore, Surgeon General Parran, General Rankin, Dr. G. Canby Robinson, Colonel Rowntree, Colonel Rusk and General J. S. Simons. They tell of the preparations for D-Day, of the preventive medicine training to master the menace of tropical diseases. They tell of the Navy doctors at Tarawa and Guadalcanal. They tell of the mobilization of the great medical fighting force, of how at least sixty thousand are now alive who would have died with our knowledge during the first war. The book is a diversion, and a joy and satisfaction. The reader will be proud to be one of such a gallant group.

A MANUAL OF TROPICAL MEDICINE. Prepared Under the Auspices of the Division of Medical Sciences of the National Research Council; Colonel Thomas T. Mackie, MC, A.U.S., Executive Officer, Tropical and Military Medicine; Chief, Division of Parasitology, Army Medical School; Major George W. Hunter, III, Sn.C. A.U.S., Division of Parasitology, Army Medical School; and Captain C. Brooke Worth, MC, A.U.S., Division of Parasitology, Army Medical School. 287 Illustrations, 6 in Color. Philadelphia and London: W. B. Saunders Company. 1945. Price, \$6.00.

This is another of the series of volumes developed under the auspices of the National Research Council and is a quite complete treatise on parasite and other tropical diseases. It covers the epidemic diseases as typhus, dengue, yellow fever, yaws, bacillary dysentery, and the especial parasite infestations too numerous to mention, but necessary to know for the doctor who will come in contact with these diseases, and who will treat many of the returning soldiers. In preparing the book the needs of the medical student have been kept in mind as well as the military and civil practitioner. The illustrations are remarkably well selected, from the standpoint of identifying the strange diseases.

A SYNOPSIS OF MEDICINE. By Sir Henry Letheby Tidy, K.B.E., M.A., M.D., B.Ch(Oxon), F.R.C.P. (Lond). Extra Physician to H.M. the King; Consulting Physician to St. Thomas Hospital; Hon. Major General, Lately Consulting Physician to the British Army. Eighth Edition, Revised and Enlarged. Baltimore: The Williams and Wilkins Company, 1945.

Practically all medical diseases of infectious or other nature are grouped in the various classifications and quite minutely described with especial reference to diagnosis and treatment. This is done by paragraphs in outline form. The book has been revised to include the newest chemotherapy, penicillin and the Rh factor. It is well worth having as a general reference.

AUGUST, 1945

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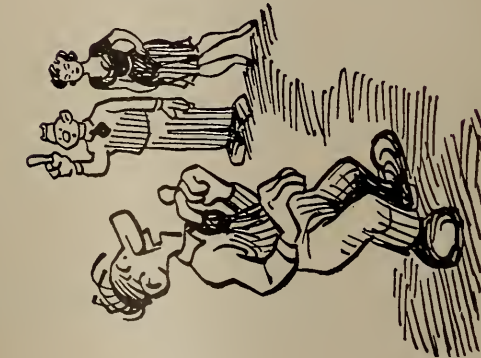
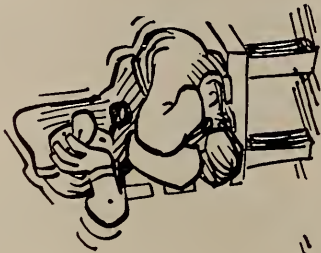
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NO 1945 SCIENTIFIC SESSION

The War Committee on Conventions denied the request of the Michigan State Medical Society to hold its Postgraduate Conference on War Medicine in 1945. Therefore, the 80th Scientific Session of the Michigan State Medical Society, scheduled for the Book-Cadillac Hotel, Detroit, September, 1945, was not held.

Plans for the 1946 scientific assembly of the State Society are already under way.

The MSMS House of Delegates held a full session in Detroit (Book-Cadillac Hotel) on Monday evening, September 17, and all day Tuesday, September 18.

MSMS Radio Hours, WJR, Detroit
Fridays—6:30 p.m., E.W.T.

EARLY SEPARATION OF UNNEEDED MEDICAL OFFICERS FROM MILITARY SERVICE

The Statement of the MSMS Council on this subject is printed on page 960. Since publishing this statement the Michigan State Medical Society has been advised that "there will be no blanket release of any group of officers, but each man must initiate his own request for discharge through channels under provisions as outlined in War Department Circular 456. The application will be considered on the requirements of the service and also the requirements of the civilian population, the officer's adjusted service rating, and the individual officer's own desire for release."—From a Michigan member of Congress.

MSMS Radio Hours, WJR, Detroit
Fridays—6:30 p.m., E.W.T.

PROLONGED USE OF NARCOTICS

To protect Doctors of Medicine from unnecessary investigation and embarrassment in connection with patients requiring prolonged use of narcotics, as well as to prevent the individual from going from one doctor to another and accumulating a supply of such drugs, the Michigan State Board of Registration in Medicine proposes that a simple record of the individual case requiring such long treatment be made by the

prescribing doctor and be forwarded to the Federal Narcotic Inspector. A brief blank, for the use of the doctor, was prepared by the Michigan State Board of Registration in Medicine and referred to The Council of the Michigan State Medical Society for approval.

The proposal, together with the form indicated below, was approved by The Council of the State Society at its meeting of July 13-14, 1945: To Federal Narcotic Inspector:

You are hereby notified that patient,

(Name) (Age) (Address)

is under treatment for _____
and is considered a chronic incurable case and requires narcotics for relief from suffering.

(Signature of physician) M.D.

(Address)

MSMS Radio Hours, WJR, Detroit
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STEPPING STONES TO REGIMENTATION

The bill of Senator Pepper et al. calling upon the Federal Government to supply obstetric and pediatric care for *all* women and children in the United States (rich and poor alike) follows the prophecy of the Special Committee on EMIC Program of the Washington State Medical Association (H. H. Skinner, M.D., Yakima, Chairman).

Months and months ago, this Washington State committee anticipated the ambitions of leftist planners in the U. S. Children's Bureau. The bulletin of Dr. Skinner's committee entitled "Stepping Stones to Regimentation" documents the various moves made in Washington, D. C., which resulted, finally in the Pepper recommendation that at least two important sections of medical practice be socialized.

The following is "proof of the pudding," resulting from the research of the Washington State Medical Society's very active group:

The Children's Bureau was directed by Congress to establish the EMIC Program for preservation of the soldier's morale. The Bureau seized the opportunity to

(Continued on Page 880)

Achievements For Tomorrow

● RHEUMATIC FEVER is one of the major, yet least understood, health problems in the United States today. It is a large factor in producing heart disease, the leading cause of deaths—394,915 in 1942*.

The cause of rheumatic fever and the mode of its transmission are not known. Treatment, therefore, has been directed, in part, toward efforts to control the disease by keeping the patient at rest. Sulfonamides and salicylates are used to help prevent subsequent attacks, the patient shielded from exposure, and fed a nutritious diet. Physicians are constantly helping in the solution of this problem by reporting their clinical observations. The need is to determine the cause and discover a drug, vaccine or serum to prevent or combat it. Until that occurs, the laity should be educated to watch for the symptoms, especially in children, and to secure prompt medical attention.

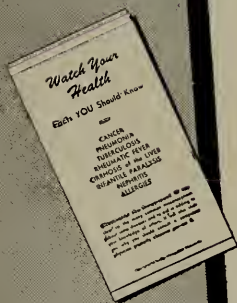
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*U. S. Summary of Vital Statistics, 1942.

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(Continued from Page 878)

regiment the soldiers' wives and the physicians of the United States by definite moves toward socialized Medical Health Centers.

Consider the following—step by step.

1. Bureau experiments with the EMIC Program to establish a precedent.

2. Bureau controls and administers entire medical and surgical care for every wife eligible for the EMIC Program.

3. Bureau plans definitely to extend and expand the EMIC Program into postwar time.—(J.A.M.A., 3/3/45. P. 530, No. 2.)

4. Bureau proposes care of ALL maternity cases throughout the country—with plans for hospitals, and proposes transportation, beginning with prematures (*Parents Magazine*—Jan., '44, and J.A.M.A.—Page 530, last paragraph. Page 531, 1st and 2nd paragraphs).

5. Bureau proposes to control ALL Children's Health by:

(a) Urging free care for ALL children of all ages (J.A.M.A., 3/3/45, P. 530, para. 3, No. 3, 2nd column).

(b) Assuming care of and making government wards of all crippled children. (J.A.M.A., Page 531, No. 5.)

(c) Working for the ELIMINATION OF COURT ACTION in determining children's eligibility for an all-inclusive bureau care (same as b).

(d) Directives for child guidance and education. (P. 531, para. 4-5 and No. 6 g.)

(e) Administering complete dental care to EVERY CHILD IN U. S. (Professional barriers must be broken down.) (News Release Children's Bureau 3/1/45.) Every dentist who objects to this program shall be overridden by Bureau!

f) The assuming of complete pediatric practice through Health Centers controlled by the Bureau. (P. 530, No. 3.)

6. Circulars, directives, committee minutes, magazine Bureau statements are all PROOF of the obvious movement to establish political medicine.

7. The Bureau is "guided" by Bureau-appointed "Steering" committees, and by "advisory" committees, also appointed, convened, and controlled by the same Bureau.

8. No recognition has ever been extended to State Medical Associations, the members of which must carry on the Children's Bureau Program.

The medical profession in Washington State feels that the Pepper proposal is an attempt to destroy piecemeal the kind of medical and dental care that the doctor in service, and the fighting man, has a right to expect when he returns home. It feels the U. S. Children's Bureau is establishing piecemeal the aims proposed in the revolutionary Wagner-Murray-Dingell Bills.

PELOUZE LECTURES

Percy Starr Pelouze, M.D., Philadelphia, Assistant Professor of Urology, University of Pennsylvania Postgraduate School of Medicine, will



Percy Starr Pelouze, M.D.

tour Michigan to present a talk on "The Modern Treatment of Gonorrhea," at the invitation of The Council and the Committee on Postgraduate Medical Education of the Michigan State Medical Society.

The Pelouze itinerary, as developed by the State Society, is as follows:

Oct. 30—Lansing (P. G. Day)
Oct. 31—Bay City
Nov. 1 (noon)—Alpena
Nov. 1 (night)—Traverse City
Nov. 2—Grand Rapids
Nov. 5—Jackson
Nov. 6—Saginaw
Nov. 7—Mt. Clemens (P. G. Day)
Nov. 8—Ann Arbor (P. G. Day)
Nov. 10—Detroit—No talk; conferences only.
Nov. 11—Detroit—No talk; conferences only.
Nov. 12—Detroit—No talk; conferences only.
Nov. 13—Flint (P. G. Day)
Nov. 14—Battle Creek
Nov. 15—Joint Meeting, Benton Harbor and St. Joseph

Where Dr. Pelouze's visit does not coincide with the regular medical society meeting or with the MSMS extramural postgraduate course scheduled for the indicated city, it has been suggested that the county society arrange a special meeting in order that the members may take advantage of this unusual opportunity.

All MSMS members are cordially invited to attend the Pelouze lecture in their own city, or in the city most convenient to them. No fee.

(Continued on Page 882)

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**// a benzedrine
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Shambaugh, G. E., Jr.,
J. Iowa State Med. Soc. 31:373-377.

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equal to, or greater than, that
produced by ephedrine.
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10 mg.; and aromatics.
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BENZEDRINE INHALER



*(Continued from Page 880)***BRINGING INDUSTRIAL MEDICINE
NEARER HOME**

The Michigan State Medical Society, for the past few years, has been very interested in promoting good industrial medical programs throughout the State. Since the great majority of the industrial workers in Michigan are employed in small plants having less than five hundred workers, most of their medical work is and must be done by the general practitioner. Many small plants have no medical programs and others provide merely a surgical service for injured employees. No comprehensive medical programs have been set up in many of these plants. Some are using nursing services where medical services or at least medical supervision should be provided.

Your State Society has sponsored an Annual Conference on Industrial Medicine and Surgery for the past three years. These meetings have been well attended, but have failed to attract many general practitioners and members of plant management who must be sold on the value of medical programs for their plants before they can be initiated.

No doubt, two of the reasons for failure to attract these groups are the pressure of wartime activity and travel limitations. To overcome these difficulties and further to stimulate and promote more adequate medical service for the small plant, the Michigan State Medical Society is now attempting a new approach, bringing these meetings nearer home and making them more attractive.

K. E. Markuson, M.D., Chairman of the Industrial Health Committee, has completed plans with C. D. Selby, M.D., Medical Director of the General Motors Corporation, whereby that organization will act as host for a fall meeting of the local medical societies in each of the following counties: Kent, Ingham, Genesee, Oakland, and Saginaw. It is hoped that the meeting of the latter society will also include Bay and Midland counties.

These meetings will be held in an industrial plant and will include an inspection tour of the various plant operations and the plant medical department, dinner at the plant as guests of General Motors, and an appropriate program for the occasion. The plant tour will, no doubt,

require considerable time and, therefore, it is planned to hold these meetings on the doctor's afternoon off, starting at 4:00 P.M.

Since plant management must be educated concerning the value of a medical service, members of management from the various local plants also will be invited.

These meetings are designed to bring about a mutual understanding of the medical problems confronting the industrial physician and the private practitioner, and should also stimulate the introduction of medical programs in many of the small plants not now providing such services.

MSMS Radio Hours, WJR, Detroit
Fridays—6:30 p.m., E.W.T.

PHYSICAL MEDICINE CENTERS AS WAR MEMORIALS

Soldier's memorials in the form of permanent establishments for the restoration of injured veterans, rather than stone and bronze monuments in public places, is the aim of the Baruch Committee on Physical Medicine founded in 1944 by Bernard M. Baruch.

The subcommittee on war and postwar physical rehabilitation and reconditioning, made up almost entirely of medical corps officers of the armed services, has been working since last February on the project and has just sent out to institutions and consultants all over the country a blueprint of an ideal war memorial. The print shows the plans for buildings, equipment and staff required for such a center and plots the courses of treatment indicated for the restoration of maimed fighting men or injured war workers to useful activity. The blueprint proposes only the basic essentials of such a center, and is subject to infinite variation to meet the special needs and limitations of large or little zones of population.

Communities generally are realizing that permanent establishments erected for the benefit of their fighting men are much more fitting memorials to them than conventional monuments set up in public parks and squares. The Baruch Committee proposes that medical centers dedicated to veterans' restoration carry appropriate lettering or tablets on their principal façades stating clearly the purpose of their erection and maintenance. It is considered, too, that the funds customarily raised in communities for war monuments may well serve as nuclei for the more practical permanent centers.

As time goes on, civilian patients, especially those injured in modern industry, may be sent to the centers by their personal physicians and surgeons, their care and treatment helping to meet expenses and overhead. The cost of treatment for military patients will, of course, be met by the Government, especially in the beginning. Ultimately such centers as the committee has in mind should be self-sustaining.

(Continued on Page 890)

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Juris ignorantia est, cum jus nostrum ignoramus—Old Maxim

NOTES ON COURT DECISIONS, STATUTES AND OTHER AUTHORITIES

J. JOSEPH HERBERT, LL.B., General Counsel, MSMS

Manistique, Michigan

THE NEBRASKA OSTEOPATHY CASE

State vs. Wagner

297 N.W. 906

Until in 1941, in Nebraska, as in most American jurisdictions, the question of the means by which an osteopath may practice the healing art had never been clearly established. The statutes authorizing the licensing of osteopaths and their practice had not been constructed by the supreme court of that state. Osteopaths were freely performing surgical operations, engaging in obstetrical procedures and using anesthetics in such practices.

The State Attorney General decided that it was high time to have the courts settle this vexing question. As a test case, therefore, he brought suit in the name of the State of Nebraska against an osteopathic physician named Gable to enjoin him from engaging in the practice of medicine and operative surgery and from publicly professing to be a physician, surgeon and obstetrician.

The defendant, a graduate of the American School of Osteopathy at Kirksville, Missouri, a school recognized by the American Osteopathic Association, had been licensed to practice in Nebraska as an osteopathic physician and surgeon. He admittedly had "performed surgical operations, including tonsillectomies, appendectomies, circumcisions, an amputation of a toe, rectal operations, hysterectomies, operations for hooded clitoris and laparotomies, all of such operations being performed with instruments and by incisions of the patients' bodies; that he has engaged in the practice of obstetrics and has used anesthetics."

On the other hand, the defendant denied that he had ever practiced medicine and asserted that as an osteopath he had the right to engage in the practice of operative surgery and obstetrics.

The lower court sustained the position of the osteopath and the attorney general appealed to the supreme court.

Unfortunately, the question whether treatment of human ailments by the administration of medicines is within the rights of an osteopath was not raised, and therefore, not determined. The sole issues which the court was called on to decide were, whether the defendant might lawfully engage (a) in the practice of operative surgery, and (b) obstetrics, and, (c) in the use of anesthetics.

To resolve these questions, the court employed a simple and direct method, which consisted in first de-

termining the meaning of the term "osteopathy" and, second, in deciding the extent to which the definition had been modified by the licensing statutes of the state.

The conclusion of the court as to the meaning of the term "osteopathy" is best expressed in its own words.

"Much has been written by the founder of osteopathy, and others learned in the practice of its profession, as to the fundamentals of the science of osteopathy. To give a résumé of these writings would unduly lengthen this opinion. We think a fair conclusion to be drawn from all of them was ably expressed in *Bragg v. State*, 134 Ala. 165, 32 So. 767, 768, 58 L.R.A. 925, where the supreme court of Alabama said: 'The method of treatment by the practitioners of osteopathy is a system of manipulation of the limbs and body of the patient with the hands, by kneading, rubbing, or pressing upon the parts of the body. In the treatment no drug, medicine or other substance is administered or applied, either internally or externally, nor is the knife used or any form of surgery resorted to in the treatment. The practitioner himself performs the manipulations. The teaching and theory of those skilled in osteopathy are that it is a system of treatment of disease by adjustment of all the parts of the body mechanically. It is taught that any minute or gross derangement of bony parts, contracting and hardening of muscles or other tissues, or other mechanical derangements of the anatomical parts of the body (which must be in perfect order mechanically in order that it may perform its function aright), nerve center, arteries, veins, and lymphatics (which must function properly in order that health may be maintained). It is taught that such interferences lead to congestion, obstructed circulation of blood and lymph, irritation of nerves, and abnormal state of nerve centers; that the result is disease, which can be cured only by righting what is mechanically wrong. * * * The essential things taught in the schools of osteopathy are anatomy, physiology, hygiene, histology, pathology, and the treatment of diseases by manipulation. The repudiation of drugs and medicine in the treatment of diseases is a basic principle of osteopathy and a knowledge of drugs or medicines, their administration for the cure of diseases, the writing and giving of prescriptions, are not

(Continued on Page 888)



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NEBRASKA OSTEOPATHY CASE

(Continued from Page 884)

essential to the graduation of, and the issuance of diplomas to, students of osteopathy.'

"The well-settled definitions of osteopathy, in the writing of Dr. Andrew Taylor Still, its founder, and in the writings of recognized practitioners, as well as in the dictionaries and the decisions of the court, all uniformly hold that the system of osteopathy administers no drugs and uses no knife. See *Nelson v. State Board of Health*, 108 Ky. 769, 57 S.W. 501, 50 L.R.A. 383; *State Board of Medical Examiners v. Baudendistel*, 140 A. 886, 6 N.J. Misc. 249; *Harlan v. Alderson*, 55 Cal. App. 263, 203 P. 1014."

To gain a correct understanding of the court's reasoning in arriving at its critical conclusion, viz., the intent to which the legislature had by statute modified the accepted meaning of osteopathy, the reader should have before him the pertinent language of the statute itself. Incidentally, a comparison of the Nebraska act with that of similar legislation of other states, will afford a criterion of the value of the instant case as persuasive authority in other courts.

The essential parts of the Nebraska statute are the following: "For the purpose of this article the following classes of persons shall be deemed to be engaged in the practice of osteopathy: 1. Persons publicly professing to be osteopaths or publicly professing to assume the duties incident to the practice of osteopathy. 2. Persons who treat human ailments by that system of the healing art which places the chief emphasis on the structural integrity of the body mechanism as being the most important factor for maining (maintaining) the organism in health." Comp. St. 1929, sec. 71-1701.

Then follow provisions for the examination and licensing of applicants. Among the requirements is presentation of proof that the applicant was graduated from an accredited school of osteopathy.

The subsequent section defines an accredited school and provides that the course of study must include the following subjects: anatomy; chemistry; pathology; toxicology; pediatrics; general surgery; obstetrics; histology; physiology; hygiene; dietetics; practice; therapeutics; general diagnosis and technique; dermatology and syphilis; orthopedic surgery; gynecology; embryology; bacteriology; comparative therapeutics; nervous and mental diseases; jurisprudence, ethics and economics; genitourinary diseases; and eye, ear, nose and throat.

Finally, the act states "Every license issued under this Division shall confer upon the holder thereof the right to practice osteopathy in all its branches, as taught in the osteopathic colleges recognized by the American Osteopathic Association." Comp. St. 1929, sec. 71-1705.

To justify his practice of operative surgery, the defendant advanced three main arguments. The first of these may be summarized as follows: inasmuch as general surgery, osteopathic surgery, anatomy, pathology and other subjects are included in the curriculum of an accredited school of osteopathy, their practice is

authorized by virtue of the following statutory language, "the right to practice osteopathy in all of its branches, as taught in the osteopathic colleges recognized by the American Osteopathic Association."

The court disposes of this contention in the following well-reasoned passage. "The words of this statute do not authorize a licensed osteopath to practice everything that he is taught in an osteopathic school. It contains expressions which have a limiting as well as an authorizing effect. The practice authorized must be osteopathic and it must also be as taught in accredited osteopathic colleges. The fact that branches of medicine and surgery may be taught to increase the knowledge of the student in the anatomy and functions of the various parts of the human body for the purpose of better fitting him to practice osteopathy will not warrant him to invade those fields on the theory that they constitute the practice of osteopathy. The scope of osteopathy is well known and schools and colleges of osteopathy must stay within its boundaries; they cannot enlarge them. *People v. Fowler*, 32 Cal. App. Supp. 2d 737, 84 P. 2d 326. In a case similar in principle, the supreme court of California said: 'While the section contains the additional clause "as taught in Chiropractic schools or colleges," the entire section must be taken as a whole and it cannot be taken as authorizing a license to do anything and everything that might be taught in such a school. A short course in surgery or one in law might be given, incidentally, and it would not follow that the section would then authorize a licensed chiropractor to engage in such other professions. It is not sufficient that a particular practice is taught in such a school. Under the terms of the statute it must meet the further test that it is a part of chiropractic, whatever that philosophy or method may be, and further, that it shall not violate the provision which expressly forbids the practice of medicine. If such a practice is not a part of chiropractic but does constitute the practice of medicine, it is not authorized under this license even though it may be taught in such a school.' In *re Hartman*, 10 Cal. App. 2d 213, 51 P. 2d 1104, 1106."

"This point is well summed up in Georgia Ass'n of Osteopathic Physicians and Surgeons v. Allen, D.C., 31 F. Supp. 206, 213, wherein the court said: 'His knowledge must be broader than his practice; he must know what he practices but may not practice all he knows.'"

The second of the defendant's arguments was to the effect that the words "osteopathic physician and surgeon" in the license implies the right to practice operative surgery. But the court was not persuaded that this is true. On the contrary, it asserted "The word 'surgery' used in its general sense in connection with the profession of osteopathy means surgery by manual manipulation and was never meant to include operative surgery as we now understand it. The correctness of this statement is evidenced by the very principles of osteopathy to the effect that the general use of a knife or other instruments in surgical operations was regarded as unnecessary and opposed to the osteopathic sys-

(Continued on Page 890)



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HEMORRHOIDAL SUPPOSITORIES

NEBRASKA OSTEOPATHY CASE

(Continued from Page 888)

tem of treatment. The practice of osteopathy and operative surgery has long been recognized as two separate and distinct things. Separate boards have been set up in this state for the examination of those applying for licenses to practice medicine and surgery and those desiring to practice osteopathy. It is urged that the principles of osteopathy have changed and that experience and learning have produced certain advances that must be recognized. If osteopathy has changed merely by a self-serving attempt to broaden its scope by invading fields requiring a different license, we can only say that the legislature has never recognized any such additions to the profession. If the changes are the result of advancements in the profession, of course, they still constitute the practice of osteopathy. But the practice of operative surgery by an osteopath is an invasion of the field of physician and surgeon as it is generally known and is not an evolutionary advancement of the profession of osteopathy. *State v. Gleason*, 148 Kan. 1, 79 P. 2d 911; *Burke v. Kansas State Osteopathic Ass'n*, 10 Cir. 111 F. 2d 250."

The third position taken by the defendant had reliance on an older statute, passed in 1919 (Comp. St. 1922, sec. 8174), which contained the provision that "osteopathic physicians shall perform only such operations in surgery as was fully taught in the school or college of which the applicant is a graduate at the time of his attendance." He argued that the legislature had thereby recognized operative surgery as a branch of osteopathy. The court quickly neutralized this position by stating, "This contention is too broad. Much of the difficulty in this class of cases has arisen because of the varied use of the term 'surgery.' It originated from the Latin 'chirurgia,' meaning 'hand work' or, as another writer puts it, 'to work with the hand.' See *American Illustrated Medical Dictionary*, 16th Ed.; *State v. Gleason*, 148 Kan. 1, 79 P. 2d 911. This is the meaning attributed to it in all the earlier writings on the subject of osteopathy and account for the general usage of the word in designating an osteopath as an osteopathic physician and surgeon. The invasion of the field of medicine and operative surgery as it is generally understood seems to be based on an attempt to broaden the definition of the term 'surgery' as formerly used so as to include operative surgery. The field cannot be so extended. The words in the 1919 act must therefore be construed as referring to operations in surgery consistent with the practice of operative surgery in its commonly accepted meaning."

And so, in deciding the first phase of the case, the supreme court categorically wrote, "We conclude therefore that an osteopathic physician and surgeon is not authorized under the statutes of Nebraska to engage in the practice of operative surgery and that the trial court was in error in holding to the contrary."

*(To be continued)*PHYSICAL MEDICINE CENTERS
AS WAR MEMORIALS*(Continued from Page 882)*

It is particularly hoped that one of the tragic conditions following the first World War may be averted—the segregation of disabled fighting men into large veterans' hospitals remote from their homes, where the personal outlook of many of the men was permanently hopeless and they passed their days in a state of mental apathy, disillusion and, in many cases, bitter resentment.

Under the Baruch Committee plan, returned veterans may be placed in centers close to their homes, where they can see their families and friends almost constantly. They will not feel neglected and forgotten. They will have, in addition, the benefit of a large variety of treatments and facilities quite new to physical medicine and only born of the present war.

There are already, in hospitals and clinics throughout the country making a specialty of physical medicine—and in the service hospitals especially—records of cures and restorations that would not have been deemed medically possible at the conclusion of the first World War. Scientifically planned and directed exercise is working wonders. The tasks that men with artificial arms and legs can do is surprising not only to the men themselves but to the physicians who have them under treatment. Best of all, the old hopelessness of a quarter of a century ago has vanished altogether.

This program could well be set up to correspond with the plan for care of our veterans as suggested by the Planning Committee for National Legislation published in our *JUNE JOURNAL*. If some definite plans are not made during the formative period, government eventually will take over all these centers in an extension of social security similar to the Wagner-Murray-Dingell proposal, or the new Pepper EMIC plan.

THE SLOAN-KETTERING INSTITUTE
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Alfred P. Sloan and Dr. Charles F. Kettering of General Motors, through the Alfred P. Sloan Foundation, have announced the appropriation of \$4,000,000 for the erection and initial maintenance of the Sloan-Kettering Institute for Cancer Research. A building will be built in the middle of the Memorial Cancer Center in Memorial Hospital grounds, New York City. The cost of construction will be \$2,000,000, and \$200,000 a year will be provided for running expenses for ten years. The present research organization of Memorial Hospital will become part of the Institute. An additional three to four million dollars will be needed to increase the bed capacity of Memorial Hospital and for equipment of the 300 bed hospital to be built by New York City on the same grounds. The completion of this program will result in the creation of a great center for cancer service and cancer research.

The new Institute will carry on its work by long range programs of research and by improving and enlarging the present type facilities for skilled clinical service coupled with continuous education of the public in the vital importance of early and effective treatment of cancer.



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SEPTEMBER, 1945

Say you saw it in the *Journal of the Michigan State Medical Society*

891

Medical Public Relations

MEDICAL AND HOSPITAL SERVICE PLANS

R. L. NOVY, M.D.:

**President Michigan Medical Service
Detroit, Michigan**

Our Michigan Medical Service and Michigan Hospital Service are service plans, not insurance or indemnity plans. At the present time, we are covering approximately 1,300,000 subscribers under the Hospital Plan and 770,000 under the Medical Service Plan. Michigan Medical Service is the largest plan in the United States and we believe it is being very successfully conducted, both from the point of view of the subscriber or the public and from the point of view of the doctor of the state of Michigan. We are not the first in this field but we have been very successful; our experience to date is twice as great as that of all other medical service plans combined.

Michigan Medical Service has been in operation for a period of five years. Over three-quarters of a million subscribers in a state containing about 6,000,000 people are covered by this plan. Let me emphasize that this plan is a medical plan controlled and administered by the Michigan State Medical Society. The members of the corporation of the Medical Service are the delegates our doctors elect each year to represent them at the State Society annual session. These delegates constitute the corporation. They elect a Board of Directors. By law, two-thirds of this Board of Directors must be Doctors of Medicine, the other one-third may be Doctors of Medicine or may be lay individuals. At all times, the policy and the direction of the corporation are in the hands of the doctors duly elected by their fellow practitioners. The actual administration, the mechanics of running this business, are in the hands of the men qualified and trained for this purpose. Mr. J. C. Ketchum, our director and vice president, has been trained in the insurance field which has problems analogous to the problems presented by this corporation. He has surrounded himself with well-qualified men in their respective fields.

\$10,000,000 Paid for Services of Doctors

In five years, this corporation has paid to the doctors of Michigan over ten million dollars for services rendered. During this year 1945, it is expected that between four and five million dollars will be paid for services rendered. Our present contract covers surgical care in a hospital. We tried the over-all coverage including hospital, office, and home care and the experience we had from this was decidedly bad. In putting in this over-all coverage, we had carefully considered the rates that would be necessary, obtaining all available data that could be obtained upon the subject. We had doubled our rates and thought we were safe in offering this service but the results were decidedly bad. We had calculated poorly. Some of the outstanding reasons for this were that we were offering service when no check on human nature was present.

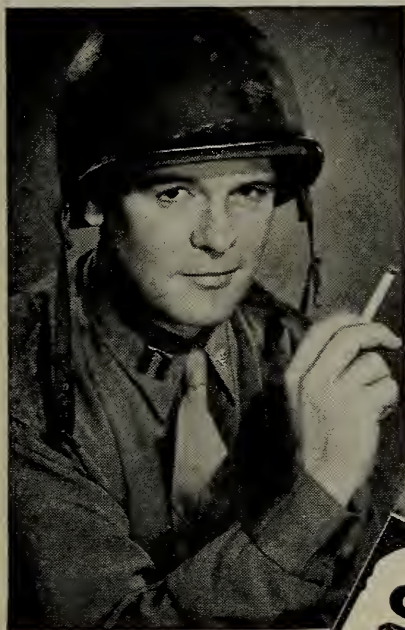
The patient was offered all services free. He delighted in having as much as possible. The doctor was paid for every service he gave. He was delighted in being called as often as possible. The result was no check and an abuse that swamped all actuarial expectations. Furthermore, we discovered that the type of over-all coverage that was offered was not the thing that the public wanted. During the time that we acquired 7,000 subscribers with an over-all coverage, we had over 250,000 who wished and obtained the surgical coverage alone. In a Survey of Public Opinion that was conducted recently in Michigan, questions covering this phase were asked with the following results: Three-quarters of the people wanted hospital and surgical coverage; two-thirds of the people wanted hospital, surgical and medical coverage while in the hospital; and only one-third of the people indicated their desire for anything approaching a home and office coverage. This survey then is exactly in line with our experience and indicated that the public is interested in the catastrophic illnesses; people feel they are well able to take care of the minor illnesses as they come along.

At the present time, we have only the surgical

(Continued on Page 896)

Discussion at meeting of Seventeen State Medical Society Presidents, Detroit, April 27, 28, 1945.

V-Day for the Doctor!



● "Good-bye, Doc—and thanks for everything!"

Yes, that's V-Day for the service doctor . . . victory in his war to *save* lives.

And doctor that he is—soldier too—he well knows how much a "smoke" can mean to a fighting man. He himself may find that same comfort and cheer in a few moments with a good cigarette. Very likely it's a Camel—for Camels are such a big favorite with fighting men—in O.D., in blue, and in *white*.



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Tobacco — Camels

MEDICAL AND HOSPITAL SERVICE PLANS

(Continued from Page 892)

coverage while in the hospital but are now embarking upon the surgical-and-medical coverage in the hospital.

Michigan Medical Service is offered throughout the state to any group of ten or more individuals working under conditions where they may be considered as a unit. Our policy calls for an enrollment of at least seventy-five per cent of any group that is to be considered. We will take any group of ten or more individuals up to the large groups such as we have in the General Motors, Chrysler, Packard, Bell Telephone Company and so on. Wherever re-coverage has been in force, our percentage of enrollment increases from year to year, indicating enthusiastic reception on the part of the public.

Family Coverage

Special notice should be given to the fact that we cover the worker's wife and dependents with exactly the same coverage accorded the worker. We also cover the wife for obstetrical services. This coverage of the family is unique with medical service plans and meets overwhelming public approval.

All licensed doctors in the State of Michigan are recognized by our plan. A free choice of physician is guaranteed thereby.

On the part of the doctor who renders the service, we can also state emphatically that enthusiasm is running high. This was not the case in the early days when the plan was started. At that time, considerable doubt was expressed by the medical profession as to the feasibility of such a medical service plan and in 1942—two years after the plan was started—a great deal of dissatisfaction was present among the medical profession. Since then an entire change has developed on the part of the profession. Michigan Medical Service today is proudly pointed to by the profession of the State of Michigan as an effectual answer to government-controlled medicine. The 1944 House of Delegates of the Michigan State Medical Society unanimously, without a dissenting vote, endorsed the successful and satisfactory results that have been obtained. Our physicians point with pride to the fact that the service that is being rendered to the public at an overhead cost for administration of 11.4 per cent

contrasting this with commercial coverage where the overhead may run 50 per cent or higher and with the fact that in England the panel system under government control has an overhead better than 80 per cent.

Let me once more invite to your attention the fact that this is a medical plan sponsored and controlled by the Michigan State Medical Society, a medical service plan that is enthusiastically endorsed by the public and by the doctors of this state. To the medical profession of the other states of the union, we urge that you investigate thoroughly what we are doing here in Michigan. We offer to you freely the experience that we have obtained, the difficulties that we have encountered, the errors that we have made and we urge upon you a careful consideration of how we here in Michigan have met the demands of the public and have offered them something and have given them something that cannot be duplicated by any form of government medicine.

L. HOWARD SCHRIVER, M.D.

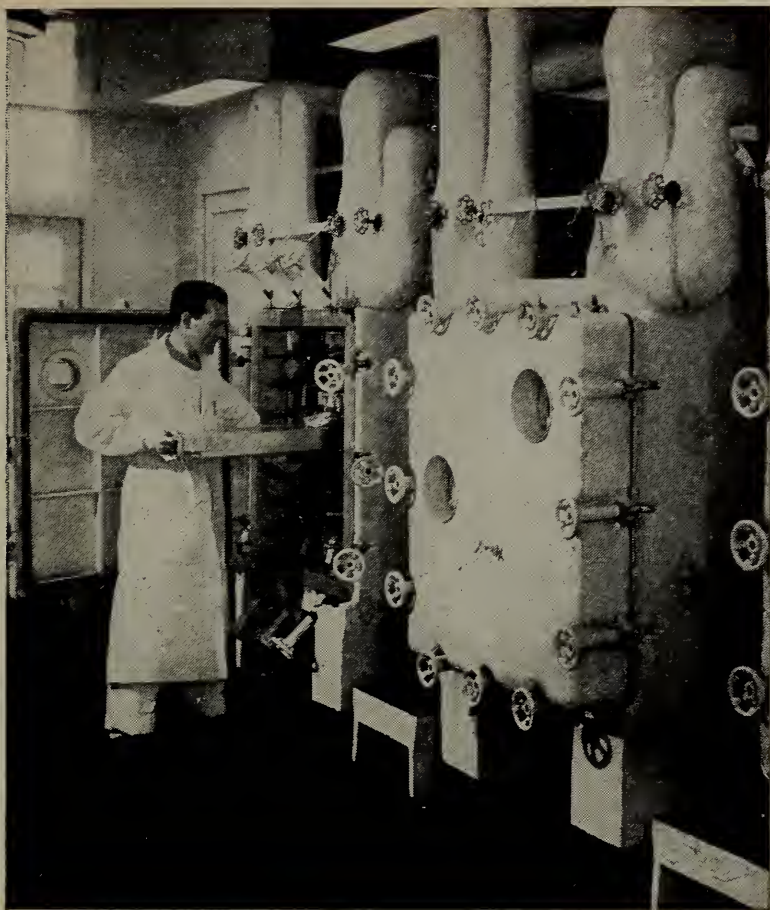
**President Ohio State Medical Association
Cincinnati, Ohio**

Upon hearing Dr. Novy describe the services rendered by Michigan Medical Service and realizing the threatening legislation confronting the medical profession of the United States, I am impressed with the fact that this situation embraces both comedy and tragedy.

It is comedy when we realize that among all of the vital services rendered the people of the United States, the services of medicine are the most widely distributed. This distribution of services has bestowed upon the people of the United States the best health of any community of the world.

It is tragic because if the plans of the social uplifter, statistician, et cetera, who have occupied the public stage for the past fifteen years, are realized it means regimentation and bureaucratic control of the medical profession and the beginning of like fate to all peoples of this great democratic country. These people, through their preachments based upon false premises, are really selling America "short," describing a picture of poverty and ill health. All this despite the fact that in no community of the world is the distribution of the comforts, conveniences, and services

(Continued on Page 900)



A Notable Production Achievement

NO less impressive than the remarkable performance of Penicillin itself is the record of Penicillin manufacturers in surmounting numerous obstacles to achieve large-scale production.

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Penicillin Merck meets the recognized high standard of quality established for all products bearing the Merck label.

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1940 Merck research on antibiotics concentrated on Penicillin

1941 Merck helped spur production through a British-American reciprocal arrangement

1942 Merck supplied Penicillin for first case of bacteremia successfully treated with Penicillin in America

1942 Merck Penicillin rushed to Boston for Coconut Grove fire casualties

1943 Merck Penicillin flown to England for U. S. Army Medical Corps

1943 Large-scale production of Penicillin was established by Merck to meet Government requirements

1944 Merck Canadian plant produced first commercial Penicillin by deep-fermentation process in British Empire

1945 Merck supplies large quantities of Penicillin for civilian use as well as for Armed Forces



MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

Political Medicine

GERMAN DOCTORS UNDER NAZISM

Shortly after V-E Day, Colonel Edward D. Churchill, Allied Mediterranean forces' surgical consultant, toured six German military hospital areas and reported his findings to American correspondents.

As we all know, *American doctors' care of wounded in this war has been and continues phenomenal as regards its record-breaking percentages of cures and its development of new techniques and remedies.* There was considerable expectation that the German doctors, what with German medicine's world-wide pre-Hitler fame and the well-known German thoroughness and energy, would have some pretty phenomenal achievements of their own to report from their war hospitals, once the Allies could crack into Fortress Europe and look around.

The Allies cracked in, all right; but Colonel Churchill did not find the phenomenal German medical achievements. His over-all conclusion after inspecting six German hospital areas was that German handling of wounded was *about twenty years behind the American procedure.*

Going into details, he reported that the German army doctors as a rule just casually passed up badly wounded men on the assumption that they were going to die anyway, whereas our doctors fight to the last gasp for every wounded man's life, and frequently win; that the German physicians never had realized the maximum possibilities of blood transfusion, and used antiquated apparatus for what transfusions they did give; that *as for professional pride in pulling off near-miracles of cure or amelioration, such pride just was not in the bulk of German military physicians and surgeons.* By and large, they were victims of an apathy and a lack of ambition which would enrage a typical American doctor.

This is a sad backslide from Germany's once proud position as world leader in medicine and surgery. How did it happen? Are there any lessons in it for us?

It began to happen soon after Hitler saddled his brand of totalitarianism on Germany. It seems reasonable to conclude that it happened *because* Hitler saddled Nazi totalitarianism on Germany.

For one thing in the Nazi philosophy, your race and *politics mattered* far more than your brains and talents. You might be a brilliant physician or surgeon or research scientist, but if you were a Jew or an anti-Nazi of any description, you had to get out of Germany if you could, or go to a concentration camp if you couldn't get out. Thus Hitler and his crew decimated German science. Their master-race convictions, too, led logically to such grisly perversions of scientific research as the use in some concentration camps of humans of "inferior" breed as guinea pigs for various laboratory experiments.

Ruled by the politicians and browbeaten by Nazi

gangsters, *German medicine*—on the strength of Colonel Churchill's findings, at any rate—*withered*, and in due time the German armed forces paid, in the form of bigger death totals than they need have suffered.

The lesson in the German experience seems clear enough. *It is that there is no substitute for a free, bold and inquisitive medical profession, or for generously financed and expertly staffed medical research, carried on year in and year out.* It is devoutly to be hoped that the lesson of the German medical collapse will not be lost on us.—Editorial, *Collier's*, July 28, 1945.

MATERNAL AND CHILD HEALTH SERVICES

A ten-year program of expanded Federal-State maternal and child health services, available to *ALL mothers and children who wish to use them*, was proposed in a bill introduced in the Senate today by Senator Claude Pepper (D., Fla.) and nine other Senators including Walsh (D., Mass.), Thomas (D., Utah), Hill (D., Ala.), Chavez (D., N. Mex.), Tunnell (D., Del.), Guffey (D., Pa.), LaFollette (Prog., Wis.), Aiken (R., Vt.), and Morse (R., Ore.).

The bill, which authorizes the appropriation of \$100,000,000 for the first year, would provide *complete maternity care, including prenatal and postnatal service*, to all mothers "who elect to participate in the benefits of the program." It would also provide *preventive, curative, and corrective services for children in home, clinic, and school, and would expand medical programs for crippled* and other physically handicapped children as well as welfare programs designed to curb child delinquency. The Federal administrative agency would be the Children's Bureau of the Department of Labor.

In introducing the bills, Senator Pepper stated:

"In my opinion, passage of this measure would result in saving the lives of many of the 7,000 mothers who now die annually in childbirth, and of many of the 118,000 children who die before reaching the age of one year. In considering this bill Congress has to keep one basic question in mind: 'Do we as a nation intend to provide every mother, regardless of where she lives or what the family income is, with an opportunity to get modern, scientific maternity care, and do we intend to see that every child, regardless of who his parents are or where he happens to be born, has a chance to receive good health care, or shall we remain content with present conditions under which some mothers and children get the best care available anywhere in the world while others get little or no skilled medical attention?'"

"We can and must prevent the wives and children of veterans of this war from suffering the neglect and ill-health that were permitted to afflict the families of veterans after the last war."

Urging speedy congressional action on the proposed program, Senator Pepper said:

(Continued on Page 900)

3 Indications

CONSTIPATION

COLITIS

DIARRHEA



One Therapy

Zymenol is indicated in either the irritable, unstable or stagnant bowel because it is a *natural approach* to the two basic problems of Gastro-Intestinal Dysfunction;

ASSURES NORMAL INTESTINAL CONTENT

... through BREWERS YEAST ENZYMATIC ACTION*

RESTORES NORMAL INTESTINAL MOTILITY

... with COMPLETE NATURAL VITAMIN B COMPLEX*

This twofold natural therapy restores normal bowel function *without* catharsis, artificial bulkage or large doses of mineral oil. Cannot affect vitamin absorption. Avoids leakage.

Teaspoon Dosage

Economical

Sugar Free

*Zymenol contains Pure Aqueous Brewers Yeast (no live cells)

Write For FREE Clinical Size

MATERNAL AND CHILD HEALTH SERVICES

(Continued from Page 898)

"We need only refer to the 40 per cent of the 22 million men of military age and to the 33 per cent of applicants for enlistment in the Women's Army Corps rejected for military duty to realize that indifference to the health of our children sooner or later strikes at the very life of the Nation. Investigation by the Senate Subcommittee on Wartime Health and Education has shown that a considerable proportion of the physical defects for which registrants were rejected could have been prevented or remedied by better health care."

To illustrate the pressing need for action along the lines proposed in the bill, Senator Pepper pointed out that at the beginning of 1944, 15,000 crippled children were listed by State agencies as awaiting medical care that they could not receive due to lack of funds under the Social Security Act.

"The time has come," he declared, "when the communities, the States, and the Federal Government must assume greater responsibility for the health and welfare of children, which their families, *rich or poor*, cannot assume alone. A co-operative program such as that proposed in this bill would increase, not lessen, the responsibility of parents to make use of the resources the community affords."

"This proposed Maternal and Child Health and Welfare Act of 1945," Senator Pepper said, "embodies recommendations made in a report of the National Commission on Children in Wartime which was recently presented to President Truman by former Secretary of Labor Frances Perkins. The bill is also in harmony with an 'Objective for Child Health in the Postwar Period,' adopted by the American Academy of Pediatrics at its last annual meeting."

The bill sets a definite time schedule for the States and the Federal Government to complete their organization of the proposed services. Within ten years, or by July 1, 1955, each State desiring to benefit from the Federal aid provided by the bill would have to establish in all its political subdivisions services and facilities to meet the health needs of all mothers and children and to make child-welfare services available to all who require them.

"The provisions of the bill assure a high quality of care, adequate remuneration to physicians, nurses, and other professional or technical personnel, and provides for the training of such personnel," Senator Pepper said. "It assures free choice of doctor, hospital, and clinic, and makes it clear that there is no compulsion on anyone—patients, physicians, hospitals, or other personnel, either to come in or stay out of the programs."

Pointing out that his bill is not in conflict with any proposals before Congress for broader medical care for all the people, Senator Pepper said:

"As the report of the National Commission on Children in Wartime states, to be most effective, the maternal and child-health and crippled children's programs must ultimately fit into a total medical-care plan designed to lift the level of health and medical care for all the people. But children do not wait to grow until the Nation decides what kind of national health program it will have. We can learn much that will be of use to us later in dealing with the larger problem by pushing ahead now with this more limited measure."

MEDICAL AND HOSPITAL SERVICE PLANS

(Continued from Page 896)

comparable to that of the United States. In no other country is the standard of living so high. Last, but most important of all, personal freedom has reached the heights, never before recorded in human history, in our United States of America.

Those who advocate Socialization of Medicine also advocate Collectivism in all human endeavor. They would make government all powerful and the governed, impotent. They are the disciples of governmental planning of human affairs yet, little do they know that governmental planning and collectivism are absolutely incompatible with human freedom—that sacred possession of Americans for which humankind has fought through the ages. Little do they know that power produces corruption and that absolute power inevitably leads to stateism, totalitarianism, and finally, dictatorship. Also they are ignorant of the fact that centralization of governmental power and direction of the use of such power by administrative agencies, result in a complete disappearance of rule by formal law that always characterizes a free country and is replaced by rule of men which only exists in totalitarian and dictator governed countries.

It is historically true that, "What has always made the State a hell on earth has been precisely that man has tried to make it his heaven."

Believing most profoundly in the foregoing statements I cannot but feel that the medical profession stands charged with a dual responsibility. First: To continue the distribution of its services as in the past, and improve this distribution as experience and knowledge indicate. Second: To resist any and all efforts to destroy its freedom. If we fail in this we not only relinquish our own freedom—we also contribute to the loss of freedom for all the people in the United States. To do this would be to sabotage Democracy. We can be masters of our destiny. Let us have resolute courage and become vocal in our community.

I hope there will be developed, from this meeting of the medical representatives of seventeen states here assembled, plans through which medicine will continue to be a free and unregimented profession with dignity, and the preservation of its American function, namely, *service to our fellow man*.

A NEW ADVANCE IN OTOLOGIC THERAPY

White's OTOMIDE

combines in a vehicle of unusually hygroscopic glycerin, sulfanilamide, urea and chlorobutanol. This new *stable* solution offers numerous advantages in topical treatment of either *acute or chronic* middle and external ear infections.

Summary of Advantages

Effective Antibacterial Activity—even in the presence of pus.

Stability—a *stable* sulfonamide-urea solution.

Wide Field—effective in *BOTH* acute *AND* chronic otologic infections.

Tolerance—physiologic pH—virtually obviating local irritation.

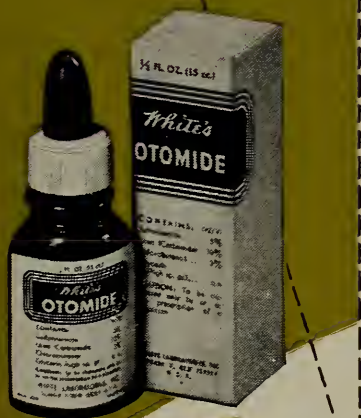
Analgesia—effective chlorobutanol analgesia *without* impaired sulfonamide activity.

FORMULA

Sulfanilamide.....	5%
Carbamide (Urea).....	10%
Chlorobutanol.....	3%
Glycerin:.....	q.s.

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*is available in dropper bottles
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—on prescription only*



White LABORATORIES, INC., Pharmaceutical Manufacturers, Newark 2, N.J.

Medical Veterans' Readjustment

INFORMATION BULLETIN FOR MEDICAL OFFICERS

A sixteen-page pamphlet on the above title has been issued by the Bureau of Information of the American Medical Association. It may be secured by a letter to the bureau, 535 North Dearborn St., Chicago 10, Ill. There is an extensive discussion of the G. I. Bill of Rights (education and loans), educational facilities in civilian institutions, answers to questionnaires, residences in specialties, graduate continuation courses, reciprocity policies and requirements, aids in establishing a practice.

Officers of the State Boards of Medical Examiners are given in table form. Basic Science board officers, and approved Examining boards in the Medical Specialties.

POSTWAR REVIEW COURSES IN MEDICINE

The House of Delegates of the Michigan State Medical Society at the meeting last September made an assessment on the membership to furnish such help as might be necessary and such information as should become available for our returning members who had been in Military Service.

To date this has been a problem of planning more than anything else. The returning men have mostly had no problem, and where there was a problem it has been met. The latest is a ruling that medical postgraduate courses shall have their tuition paid considering the time spent in the course as a fraction of the entire school year. Attempts have been made to get that regulation corrected.

To give our members an idea of what is being planned we are publishing the outline of proposed instruction courses at the University of Michigan. As received we will also pass on other programs.

POSTWAR COURSE AT UNIVERSITY OF MICHIGAN

The Medical School of the University of Michigan has formulated plans for expanding its graduate and postgraduate programs in anticipation of the greatly increased demand for educational opportunities after the war. Several different curricula have been devised in order to make them available and suitable for returning medical officers and also civilian physicians whose duties have been so engrossing that time has not permitted continuation study during the war years. The following four courses of instruction will be offered:

I. Hospital Training for Residents and Instructors (Graduate Program)

Advanced graduate training as Assistant Residents, Residents, Instructors, and Special Instructors will be made possible for physicians whose continuation study in medicine was abbreviated or interrupted by entrance into military service. This program calls for a prolonged period of instruction, concentration in a special field, and may lead to an advanced degree for candidates registered in the graduate school who satisfac-

torily complete prescribed requirements. While opportunities for graduate training of this character will be expanded beyond peacetime schedules, limited facilities will nevertheless require that priority to these appointments be given to returning medical officers.

A new position designated "Special Instructor" has been created in the various departments of the Medical School. These positions will be offered to a limited number of physicians who desire to associate themselves with the institution for a determinate tenure of office. Preference will be given to those who have previously been affiliated with the Medical School. Appointees to such positions will devote approximately one-half day to the routine work of the department and the remaining time to some type of graduate activity approved by the departmental chairman.

Applications for the above opportunities should be made directly to departmental chairmen.

II. Intensive Review Courses of Two Months' Duration

These programs have been arranged to provide instruction for physicians who desire to return for intensive training in postgraduate medicine for intervals of two, four and six months. The courses will be given in units of two months each, which may be taken separately or in any order desired. It is planned tentatively to begin these two months' courses on January 1, 1946, and to give them in the following order: (a) Clinical Application of the Basic Sciences (January and February). (b) Internal Medicine (March and April). (c) Course for Practitioners (May and June). Each course will be limited to sixty students and will not be given unless twenty apply. It is anticipated that the individual two months' courses will be repeated in response to the demand.

(a) *Clinical Application of the Basic Sciences.*—The lecture periods will consist of forty-two hours of biochemistry, thirty-six hours of physiology, twenty-five hours of pharmacology, twelve hours of psychiatry, six hours of neurology, and eighteen hours of bacteriology and immunology. It should be emphasized that some of the teaching will be conducted by members of the pre-clinical faculty, but to a greater extent by the staffs of the clinical departments. Emphasis will be placed only on the various aspects of the fundamental sciences which have an immediate bearing on the practice of medicine.

Five hours per week will be devoted to work in laboratory diagnostic methods with special attention to hematology.

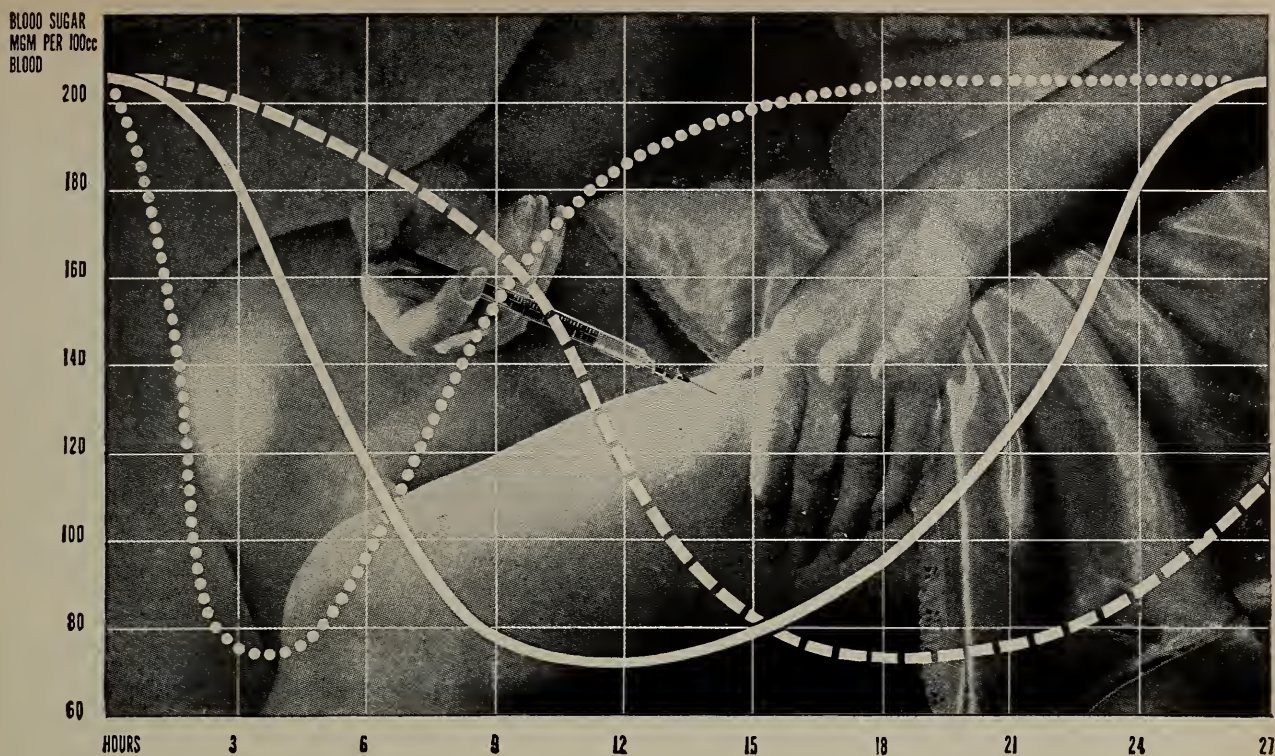
Those pursuing this course will be expected to avail themselves of the facilities of the medical library.

Physicians enrolled in this course will attend the senior medical clinics each afternoon and the weekly staff seminars of the various departments, and the Clinical Pathological Conference.

(b) *Internal Medicine.*—This course provides for attendance at special ward rounds for graduate students, two hours each morning, six days a week, and one lecture each morning. The lectures will include those dealing with gastro-enterology, heart diseases, respiratory diseases, nephritis and other kidney diseases, allergy, endocrinology, tropical diseases, infectious diseases, arthritis, vitamin deficiencies, dermatological lesions, neuropsychiatry and psychosomatic medicine, and neurological problems.

The afternoons will be given to attendance at senior clinics, medical staff conferences (x-ray and clinical), clinical pathological conferences and seminars. The lat-

(Continued on Page 904)



Today, there are 3 types of insulin...

THE PHYSICIAN now has a new intermediate-acting type of insulin with which to treat his diabetic patients—'Wellcome' Globin Insulin with Zinc. Originally there was only quick-acting, short-lived insulin. Then came a slow-acting, long-lived form. And now with Globin Insulin he has a moderately rapid-acting agent which persists for sixteen hours or more, enough to cover the period of maximum carbohydrate intake. This activity is sufficiently diminished by night to minimize nocturnal reactions. Physicians will do well to consider the advantages of this new third insulin for their diabetic patients.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York, U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc., and vials of 10 cc., 40 units in 1 cc. Literature on request. 'Wellcome' trademark registered.

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Globin Insulin
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POSTWAR REVIEW COURSES IN MEDICINE

(Continued from Page 902)

ter will deal with metabolic disturbances, heart disease, circulatory disorders, nephritis, gastro-enterology, hematology, tuberculosis and allergy.

(c) *Two Months' Course for General Practitioners.*—The teaching plan in this course is based on clinics, lectures, demonstrations and ward rounds dealing with the following topics: minor surgery in office practice; non-operative gynecology, obstetrics, otolaryngology and ophthalmology; the treatment of venereal disease; dermatology; management of fractures and dislocations; the treatment of burns; general medicine; infectious diseases; pediatrics; neurology and psychiatry; with special reference to the psychoneuroses and psychosomatic medicine. In addition, attendance at all senior clinics, medical and surgical staff and x-ray conferences is required.

This course is intended primarily for those who have been in general practice and will continue in that field, or those who anticipate entering it. The curriculum has been arranged with the view of emphasizing those topics which will be most useful to the physician in everyday practice.

III. Brief Special Review Courses

These courses are from three to five and one-half days in duration and cover the regular postgraduate subjects which have been offered by the Department of Postgraduate Medicine each spring for a number of years. Instruction of this type begins in March and continues until about the middle of June. The courses may be taken separately but they are so arranged that many may be attended consecutively for that interval, if desired. The list of courses, in the order given, and the duration of each one is as follows:

Diagnostic Roentgenology	5 days
Ophthalmology and Otolaryngology.....	6 days
Pediatrics—New Developments in Medical Supervision of Children.....	3 days
Diseases of the Blood and Blood-forming Organs	5 days
Gastro-enterology	5 days
Endocrinology and Metabolism.....	5 days
Diseases of the Heart.....	3 days
Common Problems in Differential Diagnosis	3 days
Recent Advances in Therapeutics.....	3 days
Electrocardiographic Diagnosis (November)	5½ days

IV. Half-Day Clinical Exercises for Practitioners

These courses are divided into units of one-half day each week and are repeated at weekly intervals from about September 15 to June 1. They are intended primarily for physicians who desire to attend postgraduate teaching exercises of a most practical clinical nature. The courses are divided into one-half day periods but arranged so that it is possible to extend the exercises, if desired, through a three-day interval from Wednesday morning through Friday. Hence, any one or all of the half-day courses may be attended.

The courses are as follows:

Wednesday:

9:00 A.M. to 12:00	Attendance at surgical ward rounds and operations.
1:30 P.M. to 5:00 P.M.	Surgical exercises arranged especially for practitioners.
7:00 P.M. to 9:00 P.M.	Surgical staff conference in the clinical amphitheater.

Thursday:

9:00 A.M. to 12:00

1:30 P.M. to 4:00 P.M.

4:00 P.M. to 5:00 P.M.

Psychiatry one week alternating with Dermatology the next week. In the former, emphasis will be placed on the problems of the psychoneurotic patient, while in the latter, special attention will be given to the modern treatment of syphilis.

Clinical demonstrations on selected medical topics.

Attendance at the medical staff conference. Instructive cases will be presented at these conferences together with a review of the literature pertinent to etiology, diagnosis and treatment. About 15 minutes of each conference will be devoted to a discussion and interpretation of electrocardiograms of patients on the wards.

Friday:

9:00 A.M. to 12:00

2:30 P.M. to 4:30 P.M.

Special postgraduate instruction in pediatrics and infectious diseases.

Clinical Pathological Conference.

As much of the instruction in these exercises will be bedside teaching, only 25 physicians will be admitted to the course. It is expected that attendance will be regular.

Information Concerning Admission to Courses.—Application for admission to course I should be made directly to the departmental chairman concerned; and for courses II, III and IV to Dr. Howard H. Cummings, Chairman, Department of Postgraduate Medicine, University Hospital, Ann Arbor, Michigan.

CURRENT LIST OF MEDICAL LITERATURE

The Adjutant General and The Surgeon General, Major General Norman T. Kirk, have granted permission for the Army Medical Library to take over the publication of the Current List of Medical Literature.

For the last five years this publication has been under the auspices of the Friends of the Army Medical Library and the Medical Library Association. It has rendered a great service in bringing to the attention of the Army Medical Department and the medical profession in general the latest publications in the medical field.

Mr. Ignatius McGuire, formerly in charge of indexing for the Index Catalogue, has been appointed Editor of the Current List. Suggestions from consultants or any other interested persons as to the methods of making the List a more useful publication will be welcome.

RED CROSS BLOOD BANKS

The American Red Cross has recently decided to remain in the Blood Donor field to the extent of participating with official health departments and responsible medical and hospital groups in a civilian blood program.

It was felt that in this way the program now operated for the armed forces could be escorted into the proper hands for civilian benefit. It is, furthermore, believed that the Red Cross has an obligation to the American people to pass on to responsible medical and official health groups the valuable information and the public support which has been acquired in the operation of the national program during the war period.

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Industrial Medicine

Co-operation Between Industrial Physicians, Industrial Medicine and Private Practitioners

By W. B. Harm, M.D.
Detroit, Michigan



IT may seem strange to have a general practitioner appear on the platform in a specialized program of this type as this paper can hardly be considered scientific. And yet your paths and ours cross in numerous ways. The patient that you treat daily is the one and the same that the family physician fondly calls by the misnomer, "My patient" forgetting, that so far in this grand, glorious, and free country, "my patient" is only his when he is in his office. Your contact with the patient has heretofore been during his working hours but industry is gradually extending into his off hours and into his family life. Industrial medical care plans and other social schemes are daily being invented to care for the worker in the effort to wean him away from the "cradle

to the grave" programs of an omnipotent government which may gobble up industry, including the industrial surgeon, along with the worker and his family physician.

In any of these schemes, whether they be industrial, Blue Cross, Blue Shield, or other pre-paid plans of other sources, the industrial physician will have to take in the family physician as his partner and vice versa, so it might be well for both of us to get acquainted and become friendly right at the beginning. Then these two groups will be able to co-operate and together arrive at conclusions that may be beneficial to both.

At the present time, there are ruffled feathers on both sides. The family physician feels that the industrial surgeon has taken a legitimate source of income away from him. He forgets that by law, industry (and when I use the term industry I include the insurance company who represents industry in industrial medical care) is held responsible for medical care arising in the course of employment. That being the case, they have a perfect right to say who shall render that care. When the family physician's family is ill, he demands the right to choose who shall give them medical care. It is his responsibility.

However, he feels that industry has employed cheap labor in the form of nurses and first-aid men to replace him in the minor industrial field. He doesn't mind these assistants doing minor first-aid dressing so much as he does their prescribing drugs. His patient comes to him with a history of an illness starting at work so he went to the medical department to get a release to go home. The nurse or first-aid man gave him some pills and allowed him to go home. He takes these for a day or two and when they fail to relieve his illness, he makes the delayed call on

Presented at the Third Annual Postgraduate Conference sponsored by the Committee on Industrial Health of the Michigan State Medical Society, in co-operation with the Department of Postgraduate Medical Education of the University of Michigan, Thursday, April 5, 1945, Detroit, Michigan.

his family physician. Had the industrial surgeon done the prescribing it would not have been so bad, but it would have been more co-operative if this patient were referred to his physician. There are also those cases in whom a non-industrial condition is found during the course of an industrial examination. The assistant and many times the industrial surgeon himself recommends that the man go to some certain physician for care rather than refer him to his family physician. I have even known of cases that were referred to advertising clinics in preference to the family physician. Maybe this is a matter of small consequence or maybe the industrial surgeon lacks faith in the family physician. However, the industrial surgeon can easily correct this because he is always in a position to follow up the case and so can protect the worker from poor care at a future time.

In this connection, there are other incidents of industry competing with private practice. For instance, there was a time when one of our big industries loaned its workers financial aid providing they went to a certain closed hospital which was closely related to the company. Other industries, usually low-pay organizations, will arrange hospitalization and medical care through their medical departments at cut-rate prices. We realize their workers are in the low income groups but we feel that these workers can still get proper private care. There are also quite a few industrial medical departments that do incidental laboratory and x-ray technique especially to a favored few of their workers. I have ordered an x-ray on a patient only to have him return with a plate taken at his place of employment and there was never any interpretation along. The interpretation of an expert radiologist I consider to be the most valuable part of an x-ray examination. So it is with blood smears. I have a pernicious anemia case who always gets his check up blood counts done at his plant's laboratory. Although no charge is made for these examinations, they are in direct competition with the pathologist and radiologist in private practice and even these men are entitled to a livelihood.

Speaking of laboratory work, why can't something be done regarding the unnecessary repeats of Kahn's tests? I saw one case who had five Kahns in one month, two industrial, one at the Red Cross blood bank, one for marriage, and

one at the induction center. In addition I almost took another.

On the other side, what are the duties of the family physician? If a patient comes to him with a complaint that has an industrial history, he should render minimum first aid and refer him immediately to his plant's medical department. This should be done not only for industry's information but also as a protection to the worker in case his condition might develop into one in which he might be entitled to compensation or care. Until this man has reported to his plant, the family physician should refuse further care. If, after reporting to the plant's medical department, the patient prefers the treatment of his family physician, that is the patient's own doing and the responsibility is his. It is surprising how many workers prefer the family physician for minor conditions, but as soon as they have a major accident they praise the skill and care given them by the industrial surgeon. One of the reasons for this is, I believe, that they seldom see the surgical chiefs for the minor conditions; the nurse or first-aid man handle these cases and the worker does not have too much faith in them. If the company involved authorizes continued treatment by the family physician, the physician should immediately send to the plant a report of the disability and the probable loss of time, if any, in addition to any other pertinent information on the case. At no time should he do any major surgery or surgery that might result in compensation without notifying the plant. The only exception would be an emergency involving life or death. If the case seems to be beyond the capabilities of the family physician he should immediately call in consultation, preferably an industrial surgeon. In this regard the family physician should realize that industrial surgery is a specialty in its own right and not to be confused with surgery in general. When the case is completed, another final report should be sent to the plant. In this connection, the fact that the plant has a few million in assets should not be used as a temptation to multiply his bill. There is also the case of the worker, say one with a lame back, whom the family physician treated for a week or ten days. When the patient gets back on the job, he persuades the employer that the cause was his employment. A report of the case should be sent to the employer imme-

diately, and then if he wishes to assume the responsibility, O.K.

There are any number of borderline conditions in which there is a doubt as to whether they are the result of employment or of ordinary life. The allergies, the asthmas, and the dermatitises are good examples of these. The worker gets a dermatitis, goes to the industrial surgeon and is told there is nothing about his work that could be the cause. Sometimes he even received treatment at the plant. He then goes to his family physician or many times to a dermatologist. He is skin-tested and patch-tested, covered with grease, lotion, and wet dressing but he still has his dermatitis. The only thing that seems to help is to lay off work which nets him no income. The family physician says it must be something at the plant and the industrial physician says "no" and the patient is in the middle. I'll stick my neck out and say it might even be psychotic. Why can't the family physician and the industrial surgeon get together on these cases? A few minutes consultation over the telephone would probably clear up a number of doubtful questions. Personally, I have always found the industrial surgeon more than co-operative when I have talked to him privately instead of telling the patient what to tell him. Maybe we both tell these patients too much.

Now as to the big question of the day. Someone has said that it seems that the doctors are the only honest men these days and that is why it requires a note from him before you can do anything. So we will speak of those things that industrial surgeons call the "2-buck note" and the family physician calls a "dern nuisance." We have all heard of the paper shortage and I believe a lot of these notes provide one way of getting some of the stored writing paper into war work. I'm sure most of them find their way to the waste paper basket.

First, there is the legitimate note. When a worker has actually been sick and under a physician's care, he is entitled to a statement to show these facts. This statement should include the diagnosis, the period of time he was under the physician's care and state that, in his physician's opinion, he is able to return to work. This is a confidential report and so should be given to the patient himself for the legal protection of the physician. The patient can then give

it to whomever he desires; the employment office, the gate watchman, or the medical department of the plant. For this reason the patient should also know what the note says.

But what about those notes that I call "pass the buck notes." There is the worker who is off only two or three days but the only excuse that is accepted is a doctor's certificate. He wasn't sick enough to call a physician or maybe he was one of those cases that the plant nurse's pills cured. As a result he has to come to the family physician the day he expects to go back to work and get a note. He is a good patient so what is the family physician to do? What would the industrial surgeon do in a case like this? He would examine the man first. If he shows any signs of having been ill, he would so state, also stating the date of the examination and that he is now able to return to work. If there are no signs of any illness all he can do is to repeat the patient's statement as made to him. In other words, pass the buck back to industry. When industry receives such a note, they should check it carefully and reach their own conclusions rather than tell the worker that the family physician must be a dope to write anything like that. They should realize that the family physician is trying to be honest and let industry know the true circumstances of the case. Then there is the worker who takes the long vacation. He comes to the family physician and says he is tired out plus more ailments than the malingerer at the induction center. Some of these workers are correct in their diagnosis, especially the women who are unaccustomed to the routine and monotony of factory work. There is a question in my mind as to whether these cases are entitled to an excuse or not. Of course, many after seeing the family physician once and getting a note, go down to Tennessee or Kentucky for three months to see how the farm is getting along. Then when they come back, they come to the family physician again for another note to prove they were ill the whole time. I used to refuse these but industry did not co-operate. When the worker told the employment office he couldn't get a statement, that office would give him a form telling him he was entitled to sickness insurance for the time he was off. Back to the physician he would come. On one occasion the facts of the case were truthfully stated, and imagine our surprise when

the patient returned to thank me for he had not only gotten his job back but the insurance company had also paid him for his vacation. I got paid only for the first call. In addition, at a medical meeting a few days later, I heard a variety of sarcastic remarks about "2-buck notes." By acceding to the original request I could have at least saved the insurance company some money—and they do send me an examination once in awhile. Much of this can be eliminated by insisting that the worker show that he has had medical treatment at least weekly during a layoff in which the excuse is illness. I realize that much of this is a war measure and will be obliterated when industry returns to private business, but as a warning to the industrial surgeon, you had better start a reformation now before the movement sets too much of a precedent.

Next is the worker who can't work nights because he can't sleep in the daytime, which is only one of the variety of stories used to change jobs and shifts. The industrial surgeon is no longer interested in this as it seems that industry has passed the buck on this one to the unions, whether of their own free will or at the union's demands. Even the unions are sick of the job. As for the family physician, it is bad enough to have to write excuses to settle differences between the worker and his plant or between industry and the various governmental bureaus, but when the buck is passed on from the union committee man to the family physician, that is going a little too far. When the worker comes to me and says his committee man or union steward demands a note from me, I have been telling him to go back and have the union authority send him to the U.A.W.-C.I.O. Health Clinic. It is my understanding that one of the purposes of this clinic is to settle such disputes. I don't suppose the industrial surgeon will approve of this, but I don't believe the union committee man would be able to interpret my statement and I have no desire to get into a controversy with him. They are my patients also.

The latest is a form sent out by the WLB or the WMC when a worker wants to quit his position. There is a check list on this blank of a man's abilities: no pushing, no walking, no sitting, no pulling, etc. Many men take a job and find in a couple of days they don't like it. The industry either can't or won't give them a release so down to the employment service they

go. There they are given these blanks for the family physician to fill out. These workers will never be worth their hire on the present job and unless the personnel department can find a proper spot for them, industry would be better off to let them go. Many of these men are psychoneurotics who will never stay long in any position and with the increased return of war veterans, we are going to see a lot more of this type. But why put the responsibility on the family physician and what can he say about most of them? And don't forget that the first provision of the Wagner-Dingell Bill makes the War Manpower Commission and the U. S. Employment Service a peacetime organization.

These are only a few of the statements the family physician has to write these days so don't blame him entirely if you get them in a medley of forms, on letter heads, prescription blanks or scrap paper. It would be a great help if the industrial surgeons would unite and draw up a check type of form which could be used universally in these contacts between them and the family physicians. Such a form could be printed in quantity and retailed through the local medical societies in small pads, and thus your records would not be filled with odds and ends of paper with some scribbling on them.

So much for complaints; what can we do for each other? At the present time the small industries are not fully covered by the industrial surgeon. With co-operation he could use the family physician to cover these plants. These physicians could do the pre-employment physical examinations, they could cover some of the minor first aid and even some of the plant sanitary inspection. A plan for such co-operation has already been set up in our county medical society although there has not been much progress in putting it into action. In return, the industrial surgeon has the opportunity of acting as advisor to both the employer and the worker as to the advantages of the various prepayment medical service plans and in recommending private medical care for non-industrial conditions which he finds in the course of his industrial work. Between them, they should be able to see that the worker gets complete good medical care, both industrial and non-industrial, on a basis far above the average of the governmental health plans now being advocated and at a lower cost and under more agreeable circumstances.

Industrial Medicine

Co-operation Between Industrial Physicians and Private Practitioners

By E. A. Irvin, M.D.
Detroit, Michigan



IN a discussion of this type it might be well to arbitrarily divide the practice of medicine into the following groups: (1) those engaged in the field of private practice, (2) those devoting full time to public health work, (3) those devoting full time to teaching in medical schools, and (4) those devoting full time to the practice of industrial medicine. There are three classes of physicians practicing in relation to industry: full-time, part-time, and on-call. As these designations imply, the full-time physicians alone give their whole attention to industry and that is always in one establishment. They are the only truly representative industrial medical group. The others are general practitioners or specialists who give limited attention to industry, and usually confine their work to the treatment of occupational injuries and diseases. Being in general practice and only incidentally serving industry, they can be regarded as private practitioners rather than industrial physicians, but it must be acknowledged that they furnish service to about 85 per cent of the industrial establishments in the United States. This discussion will deal with the relationship and co-operation between Group (1)—those engaged in the field of private practice, and Group (4)—those devoting full time to the practice of industrial medicine.

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It is wise to remember at the start that we are all physicians—physicians whose first principle is the welfare of the patient; second, the general health of the community. The physician in private practice may divide his responsibilities as his responsibility to his patient, to his fellow practitioners, and to the community health. The industrial physician, however, must immediately add one more responsibility—his responsibility to his management—this is not to be construed to mean that the physician's decisions are to be influenced by management, but it means that the physician must be in a position to advise management on the use of certain materials, certain processes, etc., in regard to the health of the people working in the plant. Both groups must be guided by the basic code of ethics which should guide all physicians in their dealings with one another.

Industrial medicine, as exemplified by the groups of full-time industrial physicians, is the theory and practice of medicine in relation to the health of the working people as distinguished from the case work of the private practitioner serving industry. Fundamentally industrial medicine is preventive medicine. Its basic function is health maintenance, and its object is to furnish employes the best possible health protection consistent with: (1) the purpose of industry, which is manufacturing; (2) the employer's responsibility as fixed by law, which is the care of occupational injuries and diseases; and (3) the employe's rights as to free choice of medical counsel in relation to non-occupational sickness and injuries.

This concept of the scope of industrial medicine is more inclusive than private physicians are prepared to furnish as attested by the fact that their services in industry are usually limited to the treatment of patients. Yet it recognizes their rights as private physicians, as well as those of other parties concerned in the general problem of protecting the health of the working people.

It should be remembered that industry is not in the business of practicing medicine and the ordinary employer does not wish to assume more responsibility than is required by law, while on the other hand, some employers think it wise to have a sound health maintenance program, and this in no way infringes on the rights of the private practitioner, but on the contrary should

be of great advantage to the physician in private practice.

Industrial medicine is found to comprise several functions which will be discussed under three general headings: (1) Industrial Hygiene, (2) Physical Supervision, (3) Therapy and Rehabilitation. Each will be discussed in relation to the private practitioner.

Industrial Hygiene

The physician is responsible for the hygiene of his respective plant. He is responsible for the plant environment of the working people from the standpoint of their health. He must be familiar with the materials or processes that may give rise to occupational disease if not properly controlled. It becomes his duty to see that the workmen are adequately protected, and if he finds they are not, it is his duty to inform his management and to persist until control is affected. In order to carry on this program it becomes necessary for the physician to make frequent plant inspections and to set up procedures by which new processes and new materials will be called to his attention in order that no new exposures occur without his knowledge. This is the phase of his work that was mentioned earlier as his responsibility to management—in short, it is his responsibility to advise and to assist his management in protecting the workmen against occupational diseases and other occupational impairments of health.

How does this phase of industrial medicine affect the private practitioner? Frequently patients consult their private physician and give a history of exposure to a toxic substance in the course of their work. Many times the true facts are not presented to the private practitioner, not that the patient means to be dishonest, but embarrassing failures in diagnosis have come from failures to ascertain facts as to exposure. It is, therefore, wise to refrain from reaching conclusions until the possible sources have been found adequate to be harmful. We, in industrial medicine, invite the private practitioners to consult with us concerning these alleged exposures. Industrial medicine has nothing to hide from its patients. We offer every co-operation toward helping the private practitioner to prove his case. This policy will only aid in control and prevention. A word of caution must be given to avoid

making a diagnosis based primarily on the description by the patient of work environment and materials. We will be glad to give the actual facts to you.

However, it should be remembered that when a patient consults a private physician for a condition which the private physician has a reason to believe is the responsibility of the industrial physician, the ethics of the profession would seem to dictate that the patient be referred to the industrial physician. If the industrial physician in question is not available, and it is not possible for the private physician to determine who is his substitute, then the private physician has the right, as well as the duty, to give emergency care for the patient. Only such care as is sufficient to tide the patient over the period until the industrial physician is available should be given. Questionable amputations, enucleations of the eye, tendon repairs, open reductions, and similar operations should not be done unless they are urgent.

For a private physician to treat an employee who comes to him complaining of an industrial accident or disease simply because he considers the physician who is in charge less skilled than himself or even unable at all to care for the case is not showing ordinary professional courtesy to the industrial physician in charge. If the case is such that the industrial physician does not feel able to handle it, he will refer the case to a consultant who is capable, as he has been doing in the past, and the private physician who has seen the patient first, and has made the effort to refer the patient to the industrial physician as outlined above, may be rewarded by having the case referred back to him.

If the above physician who shows these courtesies is able to care for the case in question, and the particular industrial physician is not, it should be considered ordinary courtesy on the part of the industrial physician to refer the patient to said private physician unless definite arrangements have been made with specific physicians for the management of such cases. However, in referring such cases to private physicians, who have shown the courtesies as outlined, the industrial physician must be guided by cost, all other considerations such as skill being equal. While it is not wise for an employer or insurance company to shop around for bargains in medical

or surgical service, it cannot be denied that an employer or insurance company has the same right to know what medical and surgical service will cost as does the private individual. Occasionally private practitioners will have a case referred to them as outlined above, and they may think that because the employer is a large corporation instead of an individual, the bill can be proportionately large.

Physical Supervision

In addition to a sound industrial hygiene program the industrial physician must have a program of physical supervision for all the employes of his plant. The industrial hygiene program is effective in the control of occupational disease by establishing adequate control of exposures and thereby providing the workmen with a healthy place to work.

In addition to his knowledge of the environmental exposures and their control, the industrial physician must have a record of the physical condition of the workmen on the job. This can only be accomplished by a physical examination. These examinations might be divided into the following groups: (1) the pre-placement; (2) the periodical; (3) the consultation examinations; and (4) the re-entrance examinations. The pre-placement examinations are made at the time of employment to assure safe placement. The periodical examinations are made at definite intervals if the employe has a definite exposure to an occupational disease, or frequently enough to discover a disease that might be influenced unfavorably by occupation. The consultation examinations are usually made at the request of the employe, or at a time that the employe alleges aggravation of a disease due to his occupation, or claims a definite occupational disease. The re-entrance examinations are made on employes returning to work following sick leave or a prolonged absence from work regardless of cause.

This program of physical supervision has a definite relationship with the physician in private practice because it acts as a case-finding agency, and as a result of these examinations many patients are referred to their private physician for the treatment of various conditions that need medical care. Industry has no wish to treat ailments for which it is not responsible, but realizing the importance of early treatment, it is the duty of the plant doctor to encourage workmen need-

ing treatment to seek early consultation with their private physicians.

This is a service that has a three-fold purpose—it renders a definite service to the employe if he is advised of some condition that needs treatment that he otherwise would not have been aware; it works in the interest of early diagnosis and prompt treatment, and thereby aids the private practitioner; and as a result of the first two, it establishes a more healthy working force in the plant.

The industrial physician must be cautious in making referrals for non-occupational diseases. It is a sound practice to insist that the employe consult his family physician even if the patient may be in the need of treatment from a specialist because the family physician may resent the fact that he was not given the opportunity to see the patient. One of the most common accusations made by the family physician is that the industrial physician refers cases of non-occupational disease away from the family physician.

In our health maintenance program, we do routine chest x-rays and routine blood serological tests for the purpose of tuberculosis and syphilis case finding. Neither tuberculosis nor syphilis is treated by the industrial physician, and in both instances the suspected cases are referred to their family physician for treatment. However, the industrial physician, aware of the importance of adequate follow-up, makes an honest attempt to follow up in the treatment of the tubercular, as well as, the syphilitic patient. It becomes very disheartening to the industrial physician when he encounters an utter lack of co-operation on the part of the private practitioner in follow up. This is especially true in the case of the anti-syphilitic program. The industrial physician is not benefiting materially from this follow-up, and it would seem only logical and reasonable that the private practitioner would only be too glad to give the case-finding agency, which is referring cases into his office, the highest type of co-operation. But this is not true, except in a few cases. The average private practitioner rebels against co-operating to the point of advising us periodically that the patients are receiving or not receiving their prescribed treatment. It is also very disheartening to the industrial physician who is making an honest attempt to carry on an anti-syphilitic program, to have the employes report

back that they cannot afford to take the treatment from their family physician because of the exorbitant rate which is charged. Many plant physicians have about reached the point of discontinuing routine blood serological tests because of the high percentage of patients referred to their family physician receiving inadequate or improper therapy; and I have in mind the old late latent case of syphilis which so frequently is given a full course of anti-leutic therapy starting with routine neoarsphenamine treatment, which in the opinion of good authorities is apt to cause great damage.

Occasionally, it becomes necessary for the industrial physician to temporarily reject an employe for employment either on the pre-placement or the re-entrance examination. This sometimes occurs in spite of the fact that the employe may have approval to work from his own physician, but this may be due to several reasons—the private physician may not be fully informed as to the type of work on which the patient is employed, and the job requirements may be too great for the patient at that particular time, or the patient may have had a temporary setback between the time his private physician examined him and the time he presents himself for employment. A closer type of co-operation between the private physician and the industrial physician in these cases would relieve many misunderstandings. If the private physician is in doubt as to the type of work the patient does or the job requirements, or if he wishes to recommend a restrictive type of work for a specific time, all of this could be accomplished by a telephone call which could eliminate a great many misunderstandings between the two groups.

At the time of the pre-placement examination many remedial defects are discovered, some of which may be cause for temporary rejection, or to restrict the employe as to his type of work and advise immediate treatment for his condition. These cases should all be referred to the private physician for treatment. There is occasionally reason for controversy when an applicant is rejected for employment due to a physical defect that makes it inadvisable to employ the individual on the specific job which is available, and as occasionally happens the individual returns with a note from his physician stating that he is able to do factory work. In this case, the family

physician might save embarrassment for both the industrial physician and himself if he were to telephone the industrial physician before writing such a note because the private physician, if he has been treating the patient for any length of time, may, and probably does, know the patient's physical condition better than the industrial physician; however, the industrial physician does know the job requirements, and may be able to advise the private physician about the job. If this plan is used it works out to the best interest of all concerned.

Consultations

The established plant physician, having won the confidence of the employes, will be consulted frequently for the relief of minor ailments and for advice on the treatment of conditions that may or may not have relation to occupation. This is a very delicate phase of industrial medicine. The doctor must so conduct himself as to retain the confidence of the workmen and maintain the good will of the workmen's own private physicians in general practice. It is possible, however, for him to shorten the period that ordinarily exists between the early stages of sickness and treatment by the family physician.

One of the most important duties of the plant physician is to guide the workmen desiring or needing general medical service outside of the plant. He may give temporary treatments which will enable workmen to finish a shift, he may treat injury and sickness that result from occupation, but all else must be directed into the channels of ordinary medical practice.

This phase of industrial medicine is highly regarded by management as a good will builder. It is valued accordingly. It rounds out the plant physician's health maintenance program and it behooves him to encourage it.

Therapy

The therapeutic functions of the physician in industry are necessarily limited to the care of occupational injuries and diseases, and the temporary care of minor non-occupational emergencies occurring in the plant.

In handling these conditions he practices conventional medicine and surgery, and as such his practices and procedures need not be discussed at this time. However, the important aspect of

his practice in the plant lies in his ability or courage to discriminate between the conditions he should and should not treat. He must not assume the functions of the physician in private practice.

Occupational injuries and diseases account for less than seven per cent of the total time lost from work because of physical ailments. It is readily seen that the major problem that causes loss of time from work due to injuries and sickness falls in the realm of the private practitioner. Because a large number of employees are losing time from work due to non-occupational injuries and ailments, it behooves us as physicians to give one another the highest type of co-operation in order that we might reduce this tremendous loss. We would like to encourage a closer type of co-operation, and welcome the private practitioner to call or to consult with us about the health problems of any of the employees.



SEES NO CAUSE FOR ALARM THAT VETS WILL IMPORT DEADLY PARASITES

An army medical officer, writing in the September 1 issue of *The Journal of the American Medical Association*, says there is no need for alarm that military and civilian personnel returning to the United States from the tropics will import intestinal parasites capable of producing fatal or serious diseases.

Major Harry Most, Medical Corps. Army of the United States, carried out a study on 144 of the more than 1,000 passengers returned to the United States on the liner Gripsholm in December, 1943, and found that 70 per cent of the passengers examined harbored one or more intestinal parasites.

"These parasites, for the most part, are not foreign to this country," he concluded, "and there is no basis for alarm about the spread of intestinal parasitic diseases in this country."

Major Most added that "surveys for intestinal infections should be conducted on representative groups returning to this country to detect carriers (those who harbor the parasites but are not ill) so they may be treated. Food handlers should receive special attention."

The 144 Gripsholm passengers who co-operated in the study included missionaries with many years' residence in China, Japan, Korea and the Philippines. Some of them had been in Japanese-occupied territory and in concentration camps for variable periods of time.

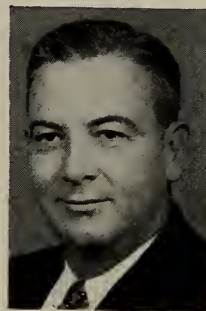
The study showed that 36 persons, or 25 per cent of the entire group examined, were infected with a type of parasite which causes chronic dysentery, intestinal ulcers and liver abscesses.

SEPTEMBER, 1945

Selective Placement of Workers

A Personnel Manager's Viewpoint

By O. L. Beardsley
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AS a preface to some of the things I shall talk about, I should like to say first of all that I don't believe the true importance of the industrial physician to manufacturing industry can be adequately described by either statistics or examples of the work. However, I do think that reference to statistics and examples having to do with the proper placement of employees will tend to illustrate a truer conception of the real importance of the industrial physician to manufacturing industry.

If you will bear with me, I would like to cite some statistics from one of the General Motors Divisions which will serve to point out the placement problems in connection with the re-employment of veterans of World War II.

However, it must be borne in mind that the placement job is not confined to the re-employment of veterans, but is a day-to-day job in the operation of any plant. I believe that a brief reference to some cases of veteran placement which we have experienced in General Motors will also serve to point up some of the later elements of this brief discussion.

In preparing for this discussion, I had a conversation with a member of our staff, who works on veteran re-employment problems, and I think that some of his viewpoints would be interesting to this group.

Presented at the Third Annual Postgraduate Conference sponsored by the Committee on Industrial Health of the Michigan State Medical Society, in co-operation with the Department of Postgraduate Medical Education of the University of Michigan, Thursday, April 5, 1945, Detroit, Michigan.

In the opinion of our Consultant on Veteran Re-employment problems, the outstanding challenge to the nation, community, family and employer is the reabsorption of servicemen into the civilian world in an orderly way and the assurance to the veteran that his opportunity will be commensurate with his capacity and the overall economic situation. It was his view that failure by Germany in the years immediately following World War I to provide equitable opportunities to German veterans and to make available capable understanding of these men as individuals—with the universal need for jobs, homes, health and recreation within the capacities of each—plowed and prepared the ground from which Nazism grew. In other words, the German community failed to do its job for its veterans and required them to band together for self-protection. The factors that made them difficult to re-absorb were the same factors that made them incapable of exercising moderation or balanced judgment. Given power to make their decisions effective, World War II was inevitable.

What does this mean to us? It means that failure to re-absorb our servicemen properly can lay the ground in which extremists and excesses can develop. Fortunately, a more positive approach is to reflect on the possibilities of advancement in this country during the coming years, if the abilities, training, capacity for effort and inherent qualities of our servicemen can be geared into the postwar civilian world in such a way as to give them free play for constructive work.

What do we know about the qualities, capacities and desires of our men after they leave the service? While the men released to date probably are, aside from battle casualties, a below average cross-section of the men in the services, we already have had some opportunity to measure the problem and to gain some insight into the more constructive channels into which our activities should be directed.

In General Motors we have long felt that proper use of human material can be made only after complete evaluations are made. I don't mean to insinuate that we have the complete answer. However, we recognize that misuse of a human is a grievous error. We also recognize that faulty maintenance is wrong. In addition, the human factors add to the complexities of per-

sonnel problems. Recognizing these matters, we have, for years, required pre-placement medical examinations as a most important step in the employment and placement processing. Because of this, and the fact that over 25,000 servicemen have been employed by General Motors, perhaps some of our experiences can assist in forecasting the kinds of problems we will face during the demobilization period and early postwar years.

Now, for a few statistics, I will cite those from one of our divisions whose experience to date is as follows:

<i>Veterans</i>	<i>Total</i>	<i>Rehire</i>	<i>New Hire</i>
Employed	619	337	282
Placed without restriction ...	533	295	238
Placed with general restriction
Placed with specific restriction.	86	42	44
<i>Impairments</i>			
Musculo Skeletal	35	15	20
Organic	29	12	17
Functional	22	15	7
Service connected disabilities ..	64	38	26
Non-service connected disabilities	45	21	22

What do these figures mean?

1. A high percentage of the men can return to work without special limitations in work assignment.
2. A high percentage, 41 per cent for the corporation as a whole, have recognized disabilities at the time of hire.
3. Musculo skeletal and organic impairments are important but perhaps more readily handled by proper job selection to assure work within the physical capacities of the individual.
4. The important percentage represented by functional disabilities points out the field in which our greatest challenge lies and our greatest opportunity for constructive work exists. This percentage has reached about 16 per cent of the total hired.
5. These figures do not include unemployables.

What is industry doing?

1. Fitting *existing* jobs to people where disabilities are essentially mechanical to the end that the disability is *not* a work limitation. *A person placed in work so that he can produce normally without undue risk to himself or others is no longer a handicapped person.*
2. Providing scientific and individual attention to all cases as *individuals* to insure most favorable placement and post-placement guidance and counselling to assure adequate and early adjustment to the new environment.

I am not going to burden this group with a discussion of too many actual cases.

An outstanding case, however, is that of Ed Savickas, as reported in the February, 1945, issue of *Ladies' Home Journal*. I am not going to take the time to cite the very interesting material which is in this article, but I do recommend it for your reading. I think it is sufficient to say that in the opinion of the personnel director at the plant where Ed Savickas is employed, this veteran would have been an institutional case had it not been for the proper attention which was given to his problems.

Another case is that of veteran "A.," a veteran of major engagements, including Midway and Guadalcanal, was discharged in May, 1943, and at time of hire in July, 1943, was physically perfect, but suffering mentally from shell shock.

Outstanding Qualities

1. Irrelevancy in answering questions.
2. Childish bashfulness.
3. Obliviousness to surroundings.
4. Free and loud use of improper language in inappropriate surroundings.

Work History

1. First two months on essentially manual work.
2. Three months on higher type of machine work.
3. Three weeks treatment at Veterans hospital—reported dementia praecox.
4. Five months on old job with improvement.
5. Entered Merchant Marine as oiler.

During period of employment he was under regular observation of the plant medical department as well as supervision and employment personnel. Not a complete cure but great improvement and useful occupation of an individual who could easily have been a permanent institutional case or special problem away from an institution.

Another case is that of veteran "X," who entered the Army in July, 1943, and was discharged January, 1944, because of a neck injury while on maneuvers. Returning to work in February, 1944, he wore a brace limiting movement of head and neck. He was approved for work with no heavy lifting. He was assigned as stock chaser but the climbing was difficult. An added restriction of ground work only was added. Placement was limited by insufficient educational background for clerical work. The coordinator and the veteran checked over many jobs to find them unsuitable because of physical requirements. The veteran did not want charity

and was becoming disgusted until sold with the idea that charity work would *not* be offered. To meet this situation some jobs in the service department were re-organized to place this man as a checker. The man has done good work and has been a great morale booster. By October, he had qualified for promotion to a supervisory position.

Where do cases of this kind lead us?

1. We shall have many cases in which medical diagnoses and recommendations are *indispensable* to the re-conditioning of servicemen to civilian life. Only the scientific knowledge and *human understanding* of the medical profession can guide us in many cases.

2. Industrial physicians are in a particularly vital position to make an almost revolutionary contribution to the solution of this community job.

3. Not all returning servicemen will be reached by industrial physicians because, unfortunately, not all employers today can offer this service to their employees.

4. Whether the services of an industrial physician are available to a veteran or not, the role of the *family* or *community* physician is of *extreme* importance and the problem is a direct challenge to their capacity to serve the community and their patients. It is an opportunity to serve in a constructive way that is unique and critical. We can lead the veteran to work. The medical profession must assist importantly in keeping him at it.

These illustrations from experiences we have had with veteran re-employment and placement, as I pointed out before, only serve to illustrate the day-to-day job which industrial physicians are called upon to do. I think, however, that the importance of this day-to-day work transcends in importance even the proper placement of men like Ed Savickas, important as these cases are.

My reason for this belief is that there are a number of ideologies being advanced today as to which is the proper way to manage industry and whether or not manufacturing industries should be conducted under a system of competitive enterprise or some other system. It is my opinion that the way in which manufacturing industry is managed by management will have a lot to do with how the people of this country decide this very important question.

The two most important elements in the management of a plant, in my opinion, are efficiency and discipline. Proper placement of people has an important bearing on both efficiency and discipline. Thus, the role played by the industrial physician in giving proper guidance to efficient

placement of people obviously has a very important effect in the final analysis in the way in which a plant is run. It is on this basis of thinking that I say that the proper placement of employees, whether veterans or non-veterans, transcends in importance any specific placement at any specific time.

In closing, I would like to pay tribute to the work of our safety men as it affects this problem. In General Motors, we do not talk of safety without also talking about our health maintenance program; on the other hand, our remarks would be incomplete when talking about our health maintenance program, if we did not take due cognizance of the importance of our safety group.

I would also like to pay a sincere tribute to the work of our industrial physicians and our industrial nurses. With tremendously expanded payrolls and with a shortage of both physicians and nurses, these people have done a marvelous job.



ASSAULTS EXAMINATION OF AIR PILOTS

"Experience in the medicine of aviation in the United States before the war led experts who are members of the Aero Medical Association and of the medical division of the Civil Aeronautics Administration to establish high standards of qualification for the examination of airplane pilots," says an editorial in the September 1 issue of *The Journal of the American Medical Association*. "On June 1 the Civil Aeronautics Administration cut the examination of private and student pilots to a minimum. Previously only qualified examiners were permitted to make such examinations. Now the examinations may be made not only by general practitioners but even by osteopaths who happen to be licensed to practice medicine in any of the states. This reversal of policy is so fraught with danger to the flying public and to the millions of persons who will be hazarding their lives in flight in the postwar period that experienced examiners now qualified particularly in this field threaten to discontinue their connection with the CAA. The Congress of the United States has placed on the CAA the duty of regulating and controlling aviation so as to 'assure the highest degree of safety.' By this backward step a federal agency is apparently permitting selfish and political pressure to force on it a disregard of the high obligation committed to it by the Congress."

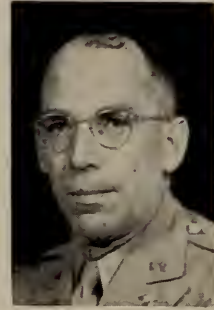
THE 1946 ANNUAL SESSION

The 1946 Scientific Session of the Michigan State Medical Society will be held at the Book-Cadillac Hotel, Detroit, on Wednesday, Thursday, Friday, September 25-26-27, 1946. The scientific program will be presented at eight general assemblies and at nine meetings of the Sections.

The House of Delegates will meet to decide the policies and to transact the business of the Michigan State Medical Society on Monday and Tuesday, September 23-24.

Health Maintenance Engineering in Relation to Industrial Health

By Major Roy P. Warren, Sanitary Corps
Army Industrial Hygiene Laboratory
Baltimore, Maryland



■ IN the past when any matters concerning industrial health have been discussed, it has been assumed that the problem was entirely medical. In later years, however, a new concept has been developed whereby it is now recognized that this problem requires not only the attention of medical men but also that of personnel men, industrial hygienists and engineers, each a specialist in his own field who recognizes the role of the other specialists.

Let us, as a basis for my part of this discussion, resolve the general problem of industrial health into its various components. The end result is quite simple—either a work room is a healthful place in which to work or it is not, and either a workman is well or not—the factors contributing to these conditions, however, are a little more complex.

First of all, what a person should not do must be determined by the physician by means of a preplacement medical examination. Results of such an examination will show whether the applicant can do any type of work or whether he should not perform some special operation involving lifting, standing for protracted periods, working under extremely noisy conditions or performing delicate operations, and many, many other

Presented at the Third Annual Postgraduate Conference sponsored by the Committee on Industrial Health of the Michigan State Medical Society, in co-operation with the Department of Postgraduate Medical Education of the University of Michigan, Thursday, April 5, 1945, Detroit, Michigan.
(Publication approved by the Office of the Surgeon General, United States Army.)

things too numerous to mention here. Certainly an engineer has no business defining this phase of the problem.

Next, the personnel manager comes into the picture in considering the proper placement of the applicant, or in many instances, in the consideration of a transfer for an active employee. This personnel manager must interpret the physician's report, and in doing so he must know the operations and working conditions to which the applicant will be assigned.

It is when we discuss operations and working conditions that engineers and chemists enter the picture, and it is this particular phase upon which I wish to elaborate. The first clean-cut engineering issue which affects working conditions would be a consideration of exposures to substances which are hazardous to health. In this consideration the processes responsible for exposures should be studied. In general, processes commonly encountered might be listed as follows:

- (a) Painting
- (b) Bench cleaning
- (c) Degreasing
- (d) Welding, brazing, and soldering
- (e) Blast cleaning
- (f) Foundry work and heat treating
- (g) Warehouse activities
- (h) Engineer repair and testing
- (i) Plating
- (j) Paint removing
- (k) Grinding

In the Army, just as a matter of general information, it is necessary to add a few processes, such as:

- (a) Ammunition manufacture and preparation
- (b) Proof firing
- (c) Rubber repair

The major exposure would be from the use of solvents. Then a miscellaneous list of exposures would follow such as:

- (a) Lead
- (b) Dust
- (c) Paint mists
- (d) Carbon monoxide
- (e) Miscellaneous chemicals
- (f) Welding fumes
- (g) Acid mists
- (h) Dermatitis-producing agents
- (i) Oxides of nitrogen

Some exposures common to Army operations which are probably not commonly found in industry would be such items as:

- (a) Tetryl
- (b) TNT
- (c) Bromotoluene
- (d) Radio active materials

An engineering approach to the general problem of control of these types of exposure would be, first of all, to see whether it is possible to substitute an innocuous material for one which is hazardous. The process should then be studied to see whether some process change might be made whereby the dust, fume, or gas could be suppressed or eliminated. In lieu of any of these control measures it is sometimes possible, due to the size of the operation or to its infrequency, to rely on isolation of the process.

By and large, however, none of these general methods just described are applicable, and the engineer is called on to control the hazard by means of ventilation. Experience has indicated that the following procedure is the most successful:

(a) An appraisal of the situation is made. This work is generally performed by an industrial hygienist skilled in taking atmospheric or material samples, or both. This particular phase of the work calls for the use of specialized sampling equipment together with specialized training in the use of the equipment.

(b) The samples thus obtained are generally sent to a chemical laboratory for analyses, whereby the magnitude of the exposure is determined.

(c) An evaluation is then made, generally by the industrial hygienists, as to whether a health hazard exists. In making this determination the industrial hygienist is governed by his knowledge or by collective knowledge as to what concentration of an atmospheric contaminant is permissible for the normal hours of work. For example, if exposure to a solvent, such as benzol, is involved, it is general practice to accept 100 parts of benzol per million parts of air as the maximum allowable concentration. If the concentration of benzol exceeds this amount, corrective measures are indicated. If the exposure is less than this amount consistently, it is generally accepted that the working environment is safe. However, the amount of contact must be observed before giving full approval of the working environment because the possibility of contact dermatitis should be guarded against.

(Continued on Page 958)

THE MICHIGAN POSTGRADUATE PROGRAM FOR GRADUATES IN MEDICINE Autumn, 1945

The Michigan State Medical Society, in co-operation with the University of Michigan Medical School, Wayne University College of Medicine, the Michigan Department of Health, and the Wayne County Medical Society, announces the extra-mural postgraduate courses for the autumn, 1945.

Centers	Dates
Ann Arbor	October 11 and November 8
Battle Creek	October 2 and 16
Flint	October 9 and November 13
Grand Rapids	October 9 and November 13
Lansing	October 30 and November 20
Mt. Clemens	October 10 and November 7
Saginaw	October 16 and November 20
Traverse City	October 10 and November 12

Subjects

1. Some Practical Considerations in the Use of Drugs in the Relief of Pain.
2. The Acute and Subacute Respiratory Infections in Childhood.
3. The Avoidance of Pitfalls in the Diagnosis of Gastro-intestinal Complaints.
4. The Management of Breech Deliveries.
5. Genito-Urinary Emergencies.
6. The Modern Treatment of Gonorrhea.

INTRAMURAL COURSES

Clinical Internal Medicine	September 13 to December 20. Thursday afternoons, 1:30 to 5:30 P.M., E.W.T. Ward rounds and clinical conferences by the Senior Staff of the Department of Internal Medicine. University Hospital, Ann Arbor. Enrollment limited.
Electrocardiograph Diagnosis	November 5 to 10, inclusive. University Hospital, Ann Arbor. Enrollment limited.

Annual Postgraduate Medical Conference, Rackham Building, Ann Arbor. Canceled for 1945 in conformity with travel regulations by Office of Defense Transportation.

The detailed program will be mailed to physicians in the State early in the autumn. For further information, address:

COMMITTEE ON POSTGRADUATE EDUCATION
Room 2040, University Hospital
Ann Arbor, Michigan

Editorial

FOURTEEN POINTS

THE COUNCIL on Medical Service and Public Relations and the Board of Trustees of the American Medical Association on July 19, 1945, issued a release to the metropolitan press setting up a platform of fourteen points to constitute "A Constructive Program for Medical Care."

Now, no one can say the American Medical Association is always opposing, that there is no leadership, and no positive program. This assumption of leadership by the newest Council of the Association, headed by our keenly active friend from Ohio, E. J. McCormick, M.D., is most reassuring. This "baby" among the American Medical Association Committees has done an unexpectedly great job promulgating a POSITIVE program from the A.M.A. level which is not only necessary but imperative. We have all opposed programs of regimentation. Some proposal should be made that will work, and that the profession could support. Michigan and other states for months have advocated a positive approach.

Most of the State Medical Societies, Michigan included, and some specially organized societies, have been actively fighting the regimentation plans facing us. For months the Council of the Michigan State Medical Society felt the need of active attack, and at the February 20, 1945, meeting authorized the appointment of a Drafting Committee on National Legislation. Michigan is proud of the fact that its Council and its Drafting Committee have proposed so many of the Fourteen Points now made the acknowledged platform of the A.M.A.

We congratulate the profession on this new-found bulwark of strength. The Social reformers are becoming ever more resourceful and will require more constant watching. Last month we invited attention to the new tactics of Wagner, Murray, Dingell, and that particular piece of legislation. In another column (Page 878) is outlined the Children's Bureau activities leading to a Bill by Senator Pepper for a ten-year program for maternity and child health for everyone, no restrictions, an all-inclusive federal medicine bureau!

There was the attempt to assign medical of-

ficers to the Veterans Bureau and thus take over that service on a federal basis. That particular one was nipped because it was too brash. We are now hearing some complaint, not too tangible at present, of the use of medical officers to take care of civilian persons at some of our general hospitals, retaining in the service for this work doctors who might be released for civilian practice and possibly take care of these same patients as private patients.

Dr. McCormick's new Council by prompt action and the pushing of the fourteen points may be able to offer some attractive outlet that the "do gooders" could unite on. It is worth trying.

INDUSTRIAL MEDICINE

MICHIGAN physicians today are playing a most important role in the pursuance of total war. Approximately one-third of our membership is serving our Armed Forces, which has greatly increased the responsibility of those left at home to serve the civilian population. This added responsibility has demanded its toll as is evidenced by the tremendous increase in morbidity and mortality rates in our group. Long hours in the office, hospital and at the bedside have not deterred many physicians in private practice from spending time in our industries keeping the industrial workers fit and on the job so that the production of war material has been maintained.

Michigan leads all other states in war production. Our industry employs about 1,200,000 workers. Many physicians in private practice are spending from one hour per week to two or three hours per day taking care of the medical problems that arise and also becoming familiar with plant operations and their attendant health hazards. In this manner, women, older workers, and those not acceptable for military service are placed at jobs commensurate with their mental and physical abilities.

A great demand for medical service in industry has been created as a result of wartime activity. However, a majority of the small plants, where most of the industrial workers are employed, have not developed good medical programs. With the

reconversion of industries to peacetime production, many entirely new problems will arise. The rehabilitation of returning veterans and the exposure to new substances in the manufacturing processes will create new problems concerning the placement of workers and maintenance of health which only a physician can properly administer.

Rapid strides have been made in the development of plant medical programs during this war period and every effort should be made to continue this progress. Similar gains were made during the last war, only to be lost or discarded when peace was proclaimed. Management and labor are now very health conscious and we as physicians must be ready to provide an adequate service for them. We must look forward to greater participation in the problem of industrial health in the postwar period.

KENNETH E. MARKUSON, M.D.

CHILDREN'S BUREAU, DEPARTMENT OF LABOR

A TEN-YEAR program of expanded Federal-State maternal and child health service, available to ALL MOTHERS and CHILDREN (rich or poor) who wish to use them was proposed by a bill introduced in the Senate, Thursday, July 26, 1945, by Senator Claude Pepper (D., Fla.) and nine other Senators. The bill which appropriates \$100,000,000 for the first year, would provide "*complete maternity care, including prenatal and postnatal service, to all mothers who elect to participate in the benefits of the program.*" It also includes Dental services. This is all to be provided in the Children's Bureau of the Department of Labor.

When the EMIC program started we asked where it would lead. Here it is. This is an extension of the service to make it much more inclusive, and makes it available to every mother and child in the nation. It is inconceivable to see any more expansion, except just one thing, and that will be the next step—Wagner, Murray, Dingell. This is an EMIC program (an emergency) extended to cover home, office, hospital, dental, corrective, diagnostic, preventative, curative, and would expand medical programs for crippled and other physically handicapped children, as well as welfare programs designed to curb child delinquency.

How could it be more inclusive? The text of the bill is not provided; just Senator Pepper's news release (see page 878) extolling the bill and its benefits. "The passage of this bill would save the lives of 7,000 mothers who die annually in childbirth, and of many of the 118,000 children who die before reaching the age of one year." Would that the saving of these lives were as simple as all that!

"We can and must prevent the wives and children of veterans of this war from suffering the neglect and ill-health that were permitted to afflict the families of veterans of the last war," the senator's news release states. And to do that he does not *prolong* the EMIC program, he *expands* it to cover everything that can happen to these wives or children, and makes it cover all wives and children in the nation.

Again an emergency measure to which all people were inclined to agree has been seized upon to promote a permanent revolutionary "reform." When EMIC was first proposed we remarked that "Nothing is so permanent as an emergency expedient."

NAZI MEDICINE

THE FIGHT against advancing Nazism in medicine has been one of medicine's most compelling tasks. It has been one of those problems where we have been told by national leaders that the solution must be on the local level—that the county medical societies must decide what they want, and then the national organization will take over and implement the program. That would be sufficient for an age-old evolutionary process which is essentially the evaluation and development of cultural and sociologic changes in the life of a people. But this change through which we are now going is revolution being guided by a considered and directed movement in which a strange philosophy is being forced upon a free people, and every artifice and circumlocution is being used.

We have just lived through and been an unwilling participant in the domination and seizure and ultimate destruction of a great people and a great nation. We have witnessed the grasp of power of a determined group which did not hesitate in the slightest to use methods of questionable or criminal import. And we have seen the

world ultimately revolt and destroy this insane power.

Collier's in its Editorial, quoted in full on page 898, has seen deeply into the future of medicine under the restraints that have been attempted just as insidiously and just as determinedly, and tells us of "the sad backslide of German medicine ruled by the politicians and brow beaten by Nazi gangsters." Political control of the proud world leader in medicine and surgery in just a few short years put them twenty years behind the free untrammelled profession of American Medicine in its ministrations to our soldiers and sailors in this tragic war.

This is a very welcome change of attitude on the part of Collier's, recalling the article by one of their editorial staff, Amy Porter, January 27, 1945, and we gladly congratulate Colliers on their editorial.

Medicine is headed straight for Nazism in America. Our opponents are of no mean ability. They are as shrewd and far seeing as those who attempted to seize world power in Germany. The orderly and directed attacks are coming with ever greater regularity, and to wait for direction of this fight at the lower level is to invite calamity. *We must have leadership of magnificent quality on the national level.*

ARMY MEDICAL SERVICES

FRIDAY, JULY 27, 1945, the Army Medical Department proudly celebrated its 170th Anniversary and was able to point to several outstanding accomplishments. We quote the following from the *Detroit Free Press* of July 23 announcing the anniversary:

1. Deaths of soldiers following hospitalization are two and a half times fewer than in World War I.
2. Of each 100 wounded, seventy returned to duty.
3. The disease rate has been less than one death in a thousand men—compared with nineteen in World War I, twenty-six in the Spanish-American War and sixty-five in the Civil War.
4. Malaria has been reduced by 75 per cent since the war began.
5. The dysenteries, which once put whole regiments out of action, have occurred among fewer than ninety out of 100 men. Pneumonia killed less than 1 per cent of its victims compared with 24 per cent in the last war.

This same day the MSMS JOURNAL Editor's son returned home after three years and eleven

months over seas. He is commander of the third battalion of the tenth Infantry. With a strength of 130 officers and 3,000 enlisted men his regiment has suffered battle casualties alone of 182 officers and 4,422 men. One of his first observations was "what a tremendous job these medical officers have done. If a man got hurt, and could get to the casualty station, just over the hill out of small arms range, he was almost sure to live, the attention was so prompt and so adequate."

DON'T BE AN ISOLATIONIST

THE FOLLOWING editorial by J. J. Lightbody, M.D., in the *Detroit Medical News* so clearly expresses ideas we have tried to suggest, and does it so much better than we could, that we are pleased to copy it in full:

DON'T BE AN ISOLATIONIST

Occasionally it becomes necessary for us to go out on a limb on problems of a civic or national nature which appear to be completely divorced from the realm of medicine. For physicians to have any progressive influence in their community it is expedient for them to project their opinions and to fraternize with other people or professional groups.

In our effort to offset certain political trends, which some allow themselves to believe are inevitable, it is well to remember that public relations begin at home; not only in your office and in the hospital but in service clubs such as Kiwanis, Rotary, etc., and any other group dedicated to a worthy cause. Too many physicians have cooped themselves up in small spheres of personal activity, quite oblivious to the big game being played on the outside.

Your presence at churches, community functions, service-club luncheons, etc., would add a pleasant interest to your busy days.

Join something!

WHY ARE OUR JOURNALS LATE?

OUR READERS have borne with us for many months with a minimum of complaint when their June JOURNAL came the first week of July, the December JOURNAL about the tenth of January. Our members are entitled to an explanation. Mr. Bruce, our publisher, writes, "We have ample equipment to get all our work out on time, but we haven't enough men to put it through the plant. . . . Out of less than forty people eligible for the draft at the beginning of this war we have lost twenty-eight. Our industry is rated 'essential' but in most cases our frantic appeals to all draft boards were flatly turned down."

Another cause of delay is the large amount of color being used in the advertising. The May issue of THE JOURNAL made up sixteen forms. That is, the amount of press work and binding was the equivalent of a journal of 256 pages in black and white. The capacity of the presses has been reduced because of use of less expert pressmen, or none, and on an average one or two presses are standing idle because of no workmen.

This lateness of THE JOURNAL has another effect. Our deadline for copy for the September JOURNAL is August 10. Editorials, news items, and all material except small items in the nature of "filler," to fit in where the paging does not come out even, must go to the printer on August 10, for a journal due to be delivered September 15. That gives us thirty-five days, and the news interest is not too late. But when that (September) JOURNAL is not delivered until October, some of it is old news. JOURNAL tardiness is due to War and its disturbing influences, and we are doing the best we can. When paper shortages, man shortages, et cetera, relax, we promise a JOURNAL again on time.



INDUSTRIAL HEALTH

(Continued from Page 953)

(d) Let us now consider the situation where corrective measures are called for. This brings the engineer into play, and he has several possible courses to follow. In general, they will be as follows:

(1) Some sort of air flow system will be designed in the case of ventilation. That means that the hoods, duct work, fans, motors, drives, and in some instances arrestors will be selected.

(2) The design data will be presented in the form of plans and specifications. Reputable engineers invariably follow the same form of plans and specifications.

(3) The next step would be to obtain an approval from the industrial management for the installation of the control system. This may or may not involve considerable difficulty, depending entirely upon the setup within the industry in question. In any industry the extent of the consideration given the project generally varies directly with the cost involved. Every engineer who designs a control system hopes that he can show either a direct reduction in cost, an increase in quality, or a reduction in rejections. Sometimes it is also possible to bring about a reduction in overhead, such as insurance and compensation. Needless to say, in these instances the procedure of obtaining approval for the control system is very much shortened.

(4) After the installation of the control system is

completed, a performance test is made to show whether or not the intent of the design is accomplished.

In addition to engineering control measures, experience has shown that personal hygiene measures should be established and supervised. In other words, if a process is apparently hazardous, one may always be sure that special personal hygiene measures should accompany the engineering control program. These measures may include any, or all of the following:

- (a) Special clothing
- (b) Respirators or masks
- (c) Supervised hand and face cleansing
- (d) Showers at the end of the work day

There is one other item of particular importance—namely, plant housekeeping. Practically every industrial plant has an engineering and maintenance staff. In the past these departments have been regarded as overhead, and in many instances not enough importance has been attached to their function. I wish to pass on to you my personal conviction that poor plant housekeeping and poor plant maintenance have done more to defeat well-designed and well-constructed control systems than any other single factor. If a substantial sum of money is to be spent initiating personal hygiene programs and engineered control systems, only the most meticulous housekeeping program will keep the ball rolling and show a clean plant after a year's time.

The common objective of the management and employees is to have healthful working conditions in their plant. Great strides have been made to accomplish this in the past decade. Legislation has been enacted. Huge educational programs have been conducted, so that now management and labor alike are both aware of what they want. Along with these great strides has come a realization that the efforts of one particular professional group are not enough to meet all the requirements. It is only since labor, management, medical men and engineers have tackled this problem together that tangible results have been obtained. As proof of this I venture to say that if any of you wish to walk into one of the modern war industrial plants of today and compare conditions there with those you will find in some broken-down industrial plant, let's say forty or fifty years old, I think the difference will be just as obvious as a comparison of the old one-lung Cadillac with the last one to come off the line in 1942.

MSMS COUNCIL REQUESTS EARLY SEPARATION OF UNNEEDED MEDICAL OFFICERS FROM MILITARY SERVICE

Statement Addressed to the Surgeons General of Army & Navy,
the Air Surgeon, Procurement & Assignment Service,
and to Michigan Members of Congress

Now that V-J Day is past and the release from service of part of our Armed Forces is expected, immediate consideration should be given to the release of as many of the doctors of medicine as is consistent with the best interest of the Armed Forces and of the civilian population. Promptness in reducing the size of the Medical Corps should be the positive aim of everyone having responsibility in this field. There should never be a time when any doctor of medicine is kept in the military service with nothing for him to do professionally in connection with his military status. He should not be retained in service to perform work which could be done as well by those not trained as medical doctors. Many civilians have delayed obtaining the medical care they should have had until their regular physicians get back from the war.

Doctors of Medicine in military service have written a glorious chapter in the history of American Medicine. We point with particular pride to the record of the 2,287 Michigan M.D.'s who volunteered. Michigan was among the first states to fill and greatly exceed its quota of medical officers. It never has lagged in filling any additional demands made upon the profession by the military authorities. The outstanding service rendered by these medical officers has merited rewards in every combat area where American troops have served and are serving. The Army, Navy and Air Force should not incur the criticism of the public or of the physicians in those services by holding any physician in military service a day longer than the interest of the country requires.

If the present intention of our military author-

ities is to discharge at an early date 1,800,000 engaged in war activities, then approximately 9,000 medical officers should be made available for return to civilian practice (based on the regulation average of five doctors of medicine per thousand of personnel).

The Council of the Michigan State Medical Society urges that those in authority look upon the early and prompt release of physicians, when they can be spared, as a matter of the utmost urgency and importance. After the medical needs of all the Armed Services are satisfied, any delay in releasing a physician should be avoided as an injustice to the public, an unnecessary burden on the treasury, a source of criticism of those in authority, and unfair treatment of the doctor of medicine who is serving his country.

Respectfully submitted,

THE COUNCIL, MSMS

By

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SOCIALIZATION'S HIGH COST

No more dangerous legislation ever was laid before Congress than the Senate and House bill for amendment of the Social Security Act.

This joint measure not only proposes sweeping expansion of Social Security benefits, but a nationwide, Federally controlled personal health service the aroused and alarmed medical profession assails as "State medicine."

The bill is a menace to our free institutions for two reasons:

Its cost—\$8,000,000,000 a year;

Its Socialistic intent.

To finance this latest brain child of our leftist foes of free enterprise, the measure would levy what it soothingly calls "Social Security Contributions," but what in reality would be the heaviest taxes ever imposed anywhere, anytime, for any one purpose.

These "contributions," in effect, would be a payroll tax of 8 per cent on all individual incomes up to \$3,600 a year, four per cent of which would be paid each year by the employees and four per cent by the employers. Self-employed "contributors" would pay five per cent annually on their earnings up to \$3,600 a year. Thus an employee with an income of \$3,600 or more would pay \$144 a year for social security and social medicine and his employer would pay a like amount. Self-employed "contributors" would pay \$180 yearly if their incomes are \$3,600 or more. Others in both groups with smaller incomes would be taxed in proportion.

But the \$8,000,000,000 these "contributions" are expected to yield would not pay all the cost. It is anticipated that this staggering sum would have to be supplemented from general revenues.

The Socialist-collectivist menace of the measure is most clearly revealed by its personal health service provisions, which the Nation's doctors op-

pose and which they estimate would cost \$3,142,000,000 yearly. It would authorize the Surgeon General to arrange for all general medical, special medical, general dental, special dental, home nursing, laboratory and hospitalization needs of all Social Security beneficiaries.

The medical profession, while conceding the virtue of such goals, contends the amendments would destroy the physician-patient relationship by the introduction of a Federal administrator and the public recording of symptoms and case histories, and lower professional medical standards.

But it would do much more than that. If enacted into law the amendments would give every physician and hospital in the Nation far more patients than they possibly could accommodate. Money and materials would not be available in sufficient amounts to build the new institutions needed.

The plan is economically unsound.

It is Socialistic paternalism rampant.

Placed in our statute books, it would be just another entering wedge for those whose real goal is the destruction of the free enterprise system which made this Nation great and the creation of a collectivist society. The Federal government would assume greater and greater control over the lives of all.

If not killed by the pressure of an informed public opinion, it would pave the way for the eventual socialization of transport, power plants, newspapers, radios and even department stores.

The only virtue of the bill's medical provisions is their promise of a desirable service, but at exorbitant cost.

The bill's danger lies in its threats to the fundamental freedoms which are the foundation and inspiration of our national life.—*Pontiac Press*, August 6, 1945.

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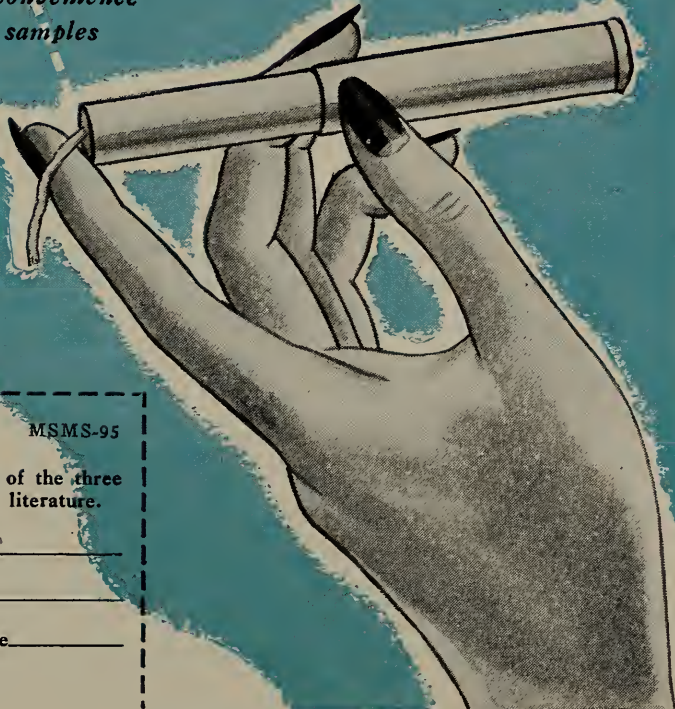
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Michigan's Department of Health

WM. DE KLEINE, M.D., Commissioner, Lansing, Michigan

DOCTOR EASLICK NEW STATE COUNCIL MEMBER

Kenneth A. Easlick, D.D.S., Associate Professor of Public Health Dentistry, School of Public Health, and Associate Professor of Dentistry, School of Dentistry, University of Michigan, was appointed by Governor Kelly to the State Council of Health for a six-year term beginning July 1, 1945.

The State Council of Health, many times called the State Advisory Council of Health because of its advisory function, is made up of five members appointed by the Governor for staggered terms of six years. The membership has, for a number of years, consisted of four physicians and a dentist.

EMIC CLARIFICATION

Following a Congressional recommendation a new interpretation of the Federal Emergency Maternity and Infant Care program went into effect July 1.

A serviceman's wife is eligible for the benefits offered by the federal government even after her husband has been honorably discharged, promoted or demoted, provided that she was pregnant during the period when he was in one of the four lowest pay grades of the services or enlisted as an aviation cadet. If the husband is a prisoner of war, missing in action or dead, the wife may apply on the same basis.

This clarification makes available the benefits of the program to wives who fail to make application before the status of their husbands is changed. Proof that the husband was in one of the eligible grades during her pregnancy entitles the wife to complete maturity service and care for her infant through his first year, including medical and hospital service.

COMMUNICABLE DISEASES

Cases of Certain Communicable Diseases in Michigan, January 1-August 3, 1945:

	Diphtheria	Measles	Meningo-coccic Menin- gitis	Scarlet Fever
State total since				
Jan. 1.....	336	3,978	196	7,226
7-year median..	143	18,070	36	7,275
	Pertussis	Poliomyelitis	Undulant Fever	
State total since				
Jan. 1.....	2,405	30	161	
7-year median..	6,662	39	75	

DDT

DDT has been used in a demonstration program for the control of flies on Mackinac Island this summer.

Beginning the second week in July, DDT was applied to the outside walls of all buildings in the business

district and to the streets and alleys. Screen doors were hand-coated with DDT. With a two-nozzle power spray carried on an old fire engine, DDT was applied to thirty stables housing some 300 horses. The public dump was also treated and thirty miles of roadway. The spraying was repeated the first week in August.

Flies have always constituted a major problem on Mackinac Island where horses are used instead of motor vehicles. The island offers an ideal situation to try DDT in controlling flies. There is little farming or fruit growing so if it kills bees or other useful insects it will not seriously affect crops.

The joint project was set up by the Mackinac Island State Park Commission, the Michigan Department of Health, Michigan State College and the U. S. Public Health Service. The War Production Board released sufficient DDT for the summer survey. Consultants on the project include: Dr. James H. Steele, Col. L. M. Fisher and Dr. Earl F. Lyman, all of the U. S. Public Health Service and Dr. Ray Hutson and Dr. Herman King of Michigan State College.

DDT (dichloro-diphenyl-trichlorethane) is a tallow-like substance which is soluble in petroleum. After it is in solution an emulsifier is added so that it can be diluted with water. One pound of DDT makes about ten gallons of liquid spray.

POLLEN SURVEY

The fifth state-wide ragweed pollen survey of the Michigan Department of Health is being carried on this summer and daily pollen counts released to the newspapers.

In the past, the Health Department Laboratories in Lansing counted the pollen collected in some fifty stations over the state. Mailing the slides to Lansing caused a delay in releasing the data. This year pollen counts for the forty-seven collecting stations are being made in seven centers: Grand Rapids, Houghton, Lansing, Mackinaw City, Powers, Saginaw and Traverse City. Each day counts will be phoned to the State Health Department's Lansing office.

Four earlier surveys have shown that in Michigan the peak of ragweed pollen contamination of the air usually occurs the last week of August or the first week of September. All studies have shown the Upper Peninsula to have much lower pollen concentrations than most of the lower peninsula. The Keweenaw peninsula consistently shows the least pollen.

Pollen collection stations cover all shore lines and also representative inland areas of the state. Pollen is collected on two-inch glass slides which are coated on one side with a thin film of vaseline and placed in a small shelter twenty-five feet above the ground. The amount of pollen collected on these slides each twenty-four hours is counted with the aid of a microscope.



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F. H. C. Baugh, M.D., Medical Supt.
The Homewood Sanitarium of Guelph, Ontario, Limited

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Woman's Auxiliary

CONVENTION CANCELLED

Even with the end of the war, the federal government is maintaining the ban on conventions because of the transportation crisis facing the nation. Consequently, for the first time in its history, there will not be an annual meeting of the Woman's Auxiliary to the Michigan State Medical Society this fall.



It is with regret that we announce this decision because we realize how important the annual convention has been to us, both as an organization and as individuals. We shall miss the opportunity for the general discussion of our plans

for the coming year, the stimulus of addresses by the officers of the Michigan State Medical Society and the national auxiliary, and—last but not least—the renewing of old friendships that we have made at these meetings in the past. However, since it is for the national welfare, we give these things up cheerfully and look forward to the time when our meetings will be resumed.

Due to the foresight of our former officers, our constitution provides for the election of officers by mail in this emergency. During the first week of September, ballots were mailed to all accredited board members and delegates. Results will be announced September 20.

To help take the place of the convention, another issue of the *Auxiliary News* will be published to summarize the year's accomplishments. Each officer, committee chairman, and county president is hereby requested to send in a report for this edition of the *News* to the Secretary, Mrs. C. F. DeVries, Box 430, Route 1, Lansing, Michigan, by October 1.

The officers of 1944-1945 wish to take this opportunity to express their appreciation to each member of the Auxiliary for their splendid co-operation this past year. Due to this, we feel that much has been accomplished for the benefit of our communities, the medical profession and our country. These have been our aims. We urge each member to extend this same co-operation to the 1945-1946 officers that we may go on to greater achievements.

MRS. H. L. FRENCH, *President*

* * *

REMINDERS TO 1944-45 COUNTY PRESIDENTS

Have you sent a list of your new officers (with addresses) to Mrs. L. C. Harvie, 417 Ardussi, Saginaw?
Have you lost any members by death? Please send their names to Mrs. C. F. DeVries.

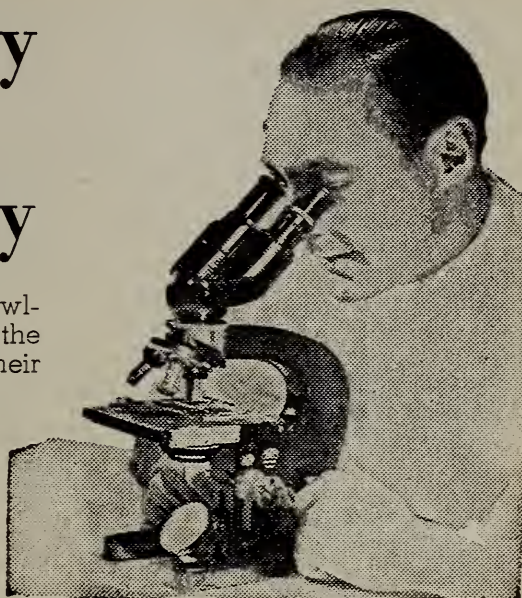
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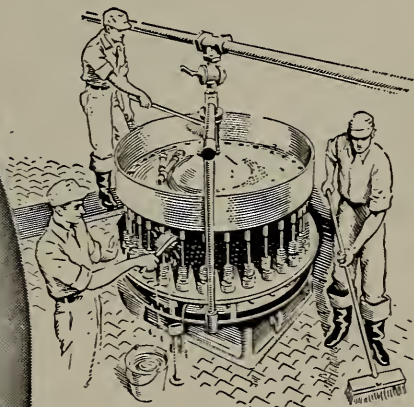
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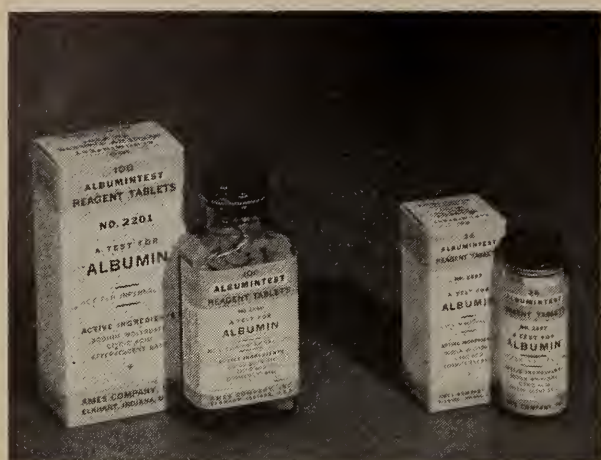
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In Memoriam

DIED IN MILITARY SERVICE

Arthur L. Benison of Edmore was graduated from the University of Michigan Medical School in 1937. He served his internship at St. Mary's hospital at Grand Rapids. Later he moved to Edmore and became associated with M. G. Becker, M.D., in the Edmore Hospital before entering service. He was a member of the first medical field unit on Bataan to be captured in the fall of the Philippines, and was lost when a Japanese prison ship was torpedoed by a submarine off the coast of China. Doctor Benison, with other American prisoners, was being transferred to Japan when the ship was torpedoed. The date of his death is unknown.

* * *

Charles D. Clark of Royal Oak was a native of Massillon, Ohio, and was graduated from the Wayne University School of Medicine in 1937. After interning at Grace Hospital, he served as staff physician at the Royal Oak Hospital. Prior to entering the service in 1942, he was on the medical staff of the Bendix Aviation Corps of South Bend, Indiana. Doctor Clark was killed when a Japanese suicide plane crashed into the United States Naval Hospital ship *Comfort*, near Okinawa. Doctor Clark was in the surgery room when the Jap pilot aimed his craft into the decks of the brightly lighted mercy ship.

* * *

Charles E. Osborn of Vicksburg was born in 1901 and was graduated from the University of Michigan Medical School in 1926. After interning at Blodgett Hospital, Doctor Osborn located in Grand Rapids. In 1928, he moved to Vicksburg, where he practiced until May, 1941, when he entered the Armed Forces. Captain Osborn was one of the first physicians in Michigan to enter service and was taken prisoner on Corregidor in April, 1942. He was held prisoner in the Davao Prison camp two and one-half years. Captain Osborn lost his life in the China Sea on October 24, 1944, when the ship carrying him to Japan was sunk by submarine action.

Clarence H. Barber of Grand Rapids was born in 1870 and was graduated from the Hahnemann Medical College and Hospital in 1891. He practiced in Hastings for forty years previous to taking up the post at the Soldiers' Home in Grand Rapids. Doctor Barber died May 18, 1945.

(Continued on Page 970)

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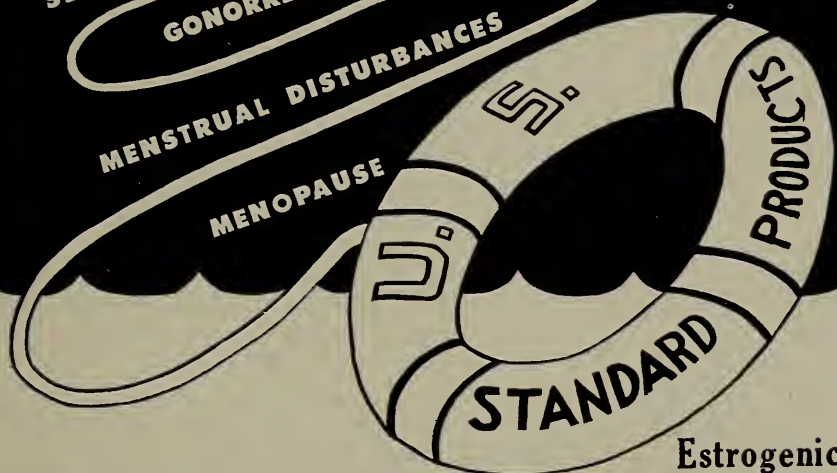


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IN MEMORIAM

(Continued from Page 968)

Horace J. Beel of Grand Rapids was born in 1887 at Kingsdon, Somersetshire, England, and was graduated from the University of Buffalo School of Medicine in 1909. After graduation, he took postgraduate work in Buffalo and Chicago. He interned at Butterworth Hospital and entered practice in 1910. In addition to staff work at Butterworth, Doctor Beel was a visiting surgeon at Blodgett and St. Mary's Hospitals. In World War I, he served as a 1st Lieutenant in the Medical Corps of the 85th Division. He first served at Langre, France, with a school detachment and later was with an operating team in combat service in France and Belgium. Doctor Beel died July 14, 1945.

* * *

J. F. Breakey of Ann Arbor was born August 10, 1870, in Ann Arbor and was graduated from the University of Michigan Medical School in 1894. He served on the University medical faculty until 1912 when he undertook private practice. In 1917, Doctor Breakey was commissioned an officer in the Medical Corps and spent the next two years at Base Hospital 17 in France. After the war, he returned to Ann Arbor where he continued private practice until his retirement in 1937. Although not practicing, he continued his work in the interests of medicine, as evidenced by a paper on Euthanasia which was published last spring. Doctor Breakey was elected to Retired Membership in the Michigan State Medical Society on September 24, 1940. He died June 26, 1945.

* * *

John E. Campbell of Brown City was born near Forest, Ontario, on May 20, 1866, and was graduated from the Detroit College of Medicine in 1892. After graduation, he moved to Brown City, where he started the practice of medicine. Doctor Campbell was prominent in county and state political circles, and took an active part in local civic affairs. He was the first mayor of Brown City and for over twenty years served on the Board of Education. He was president of the Sanilac County Medical Society in 1932-33. Doctor Campbell died June 24, 1945.

* * *

Henry R. Craig of Eloise was born February 18, 1904, in Augusta, Georgia, and was graduated from the University of Georgia Medical School in 1928, served his internship at the Wott's Hospital, Durham, N. C., and a year's residency at the Church Home and Infirmary, Baltimore, Maryland. He took further training at the Henry Ford Hospital, Detroit, and the Massachusetts General Hospital, Boston. He was junior physician for two years with the Massachusetts Department of Mental Diseases. Nine years ago, he came to Eloise as an associate psychiatrist, and for three years was senior psychiatrist in charge of the Female Psychiatric Division. Doctor Craig died June 23, 1945.

* * *

Edwin G. Low of Bangor was born December 6, 1860, in Oneida, New York, and was graduated from

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the Chicago Homeopathic Medical College in 1898. Doctor Low practiced in South Haven for one year and then moved to Breedsville in 1899. In 1900, he moved to Bangor where he remained until the time of his death. Doctor Low was widely known in the vicinity of Bangor, having practiced his profession in that area for nearly fifty years. He died July 12, 1945.

* * *

Jacob Manting of Detroit was born in 1894 in Holland, Michigan, and was graduated from the University of Michigan Medical School in 1920. From July, 1920, to July, 1922, he served as an intern and resident surgeon at the University Hospital, Ann Arbor. He then became resident surgeon at the Michigan Mutual Hospital, Detroit, where he remained until January 31, 1924. This training gave him special qualifications which later distinguished him as one of the outstanding industrial surgeons. He was a Fellow of the American College of Surgeons. Doctor Manting was a member of the surgical staff at Harper Hospital for many years. He died June 16, 1945.

* * *

Fay M. Marsh of Ionia was born in Lyons, October 22, 1875, and was graduated from the Saginaw Valley Medical College in 1900. Doctor Marsh located in Ionia in 1900. He was past president of the Ionia-Montcalm Medical Society. For many years, he was physician for the Ionia County Home and city physician of the City of Ionia. He was also on the staff of the Ionia County Memorial Hospital. He had been, for many years, a director of the State Savings Bank of Ionia and was active in many civic organizations. He died July 2, 1945.

* * *

Charles E. McMehen of Berkeley was born in London, Ontario, on April 14, 1885, and was graduated from the University of Western Ontario Medical School. Doctor McMehen practiced in Detroit for twenty-four years. He was a major in the medical corps of the Canadian Army in World War I and served three years overseas. Upon his return, he was in charge of an Army hospital at Guelph, Ontario, for two years before coming to Michigan. Doctor McMehen died July 6, 1945, after a brief illness.

* * *

W. J. Pinkerton of Ramsey was born February 11, 1873, at Waupaca, Wisconsin, and was graduated from the University of Illinois Medical School at Chicago in 1900. He practiced medicine in Eagle River before locating in Bessemer in 1906. For two years, he practiced in Ontonagon and then moved to Ramsey as a physician for the Castile Mining Company. Doctor Pinkerton served as mayor of Bessemer for two terms, 1912-1914. He died May 9, 1945.

* * *

Edward R. Ridley of Detroit was born in Duart, Ontario, May 2, 1889, and was graduated from the University of Colorado in 1911. He then studied two years at the University of Michigan. He was on the staff of Harper Hospital and was associate physician for the Detroit Edison Company at the time of his death on May 30, 1945.

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IN MEMORIAM

Benjamin A. Shepard of Oshtemo was born in Hillsdale County, July 13, 1879, and was graduated from the Detroit College of Medicine in 1904. He practiced for seven years in Plainwell and then located in Oshtemo where he founded the Pine Crest Sanatorium, spending a lifetime in the fight against tuberculosis. He was owner and director of the sanatorium until it recently was purchased by the state. He was past president of the Michigan Tuberculosis Society. He died June 16, 1945.

* * *

Frank Spencer of Detroit was born in Ridgetown, Ontario, in 1871 and was graduated from the Michigan College of Medicine in 1900. Following his graduation, he practiced in Grand Rapids for one year, then for a brief period in Detroit. Later, he located in Rockwood, Michigan, to practice for twelve years, and in 1913, he moved back to Detroit, where he was in active general practice up to the time of his last illness. He died May 19, 1945.

* * *

Vivian H. Vandeventer of Ishpeming was born in Hamilton, Virginia, January 21, 1872, and was graduated from the College of Physicians and Surgeons of Baltimore in 1906. After serving a year's internship in Bay View Hospital in Baltimore, he came to Ishpeming, in 1897, to become associated with the old Ishpeming hos-

pital, operated at the time by Joseph Vandeventer, an uncle. Later, he acquired ownership of the institution. In 1919, he became head of the medical staff of the Cleveland-Cliffs Iron Company in Ishpeming. In 1939, Doctor Vandeventer resigned as head of the hospital and entered private practice in Ishpeming. He was a long-time delegate from the Marquette-Alger County Medical Society to the MSMS House of Delegates. He died July 3, 1945.

* * *

William G. Wander of Detroit was born in 1889 and was graduated from the Washington University School of Medicine in St. Louis, Missouri, in 1919. Doctor Wander located in Detroit in 1920 where he practiced until the time of his death. He was past president of the Detroit Dermatological Society. He was also head of the Skin and Cancer Clinic, St. Joseph's Mercy Hospital, and associate dermatologist at St. Mary's Hospital, Detroit. Doctor Wander died May 21, 1945.

* * *

Adrian L. Zemmer of Port Huron was born in Port Huron August 20, 1904, and was graduated from Wayne University College of Medicine in 1934. He had practiced in Port Huron for ten years, where he lived until his death caused by accidental drowning on July 8, 1945.

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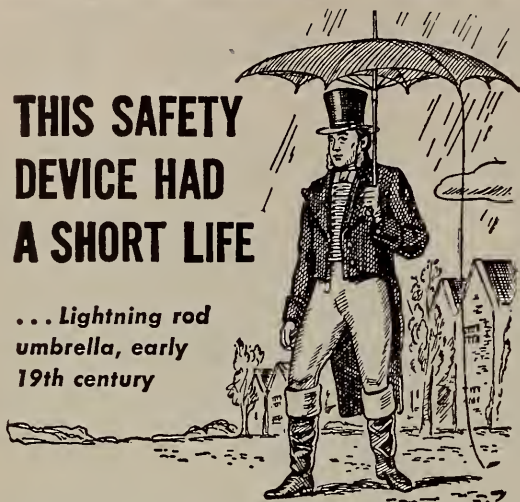
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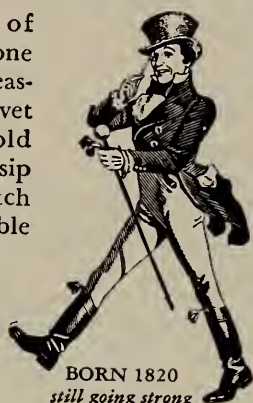
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Correspondence

To The Editor:

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ROGER MILLS RICE, Reidsville, N. C.

THE DOCTOR IS STILL "TOPS"

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Who with his chisel makes marble live;
The painter, who takes a canvas bleak,
And makes it all but live and speak;
The astronomer, who studies the mystery of night—
Weighing Celestial orbits in flight;
The composer, who gives his soul to sounds
And orators who scale the Heavenly bounds,
All win places in human hearts
For mastering their respective arts;
But he's due praise with louder refrain,
Who goes regardless of physical strain,
Day and night through shine and rain,
Lending his skill of hand and brain—
Prolonging life and easing pain.

By ROGER MILLS RICE

Mr. William J. Burns, Exec. Sec.,
Michigan State Medical Society,
Lansing, Michigan

Dear Sir:

Unofficially, I have been informed by the Secretary of the AMA that your organization may have created, or is familiar with an organization for general practitioners. If this is so, I would greatly appreciate any information you can give me about the organization, such as its aims, official standing, names of its officers and mailing address.

I desire this information in the interests of a group which may be formed in this city.

Sincerely yours,
A. J. KANTER, M.D.
Cincinnati, Ohio

2614 Woodburn Avenue.

A. J. Kanter, M.D.
2614 Woodburn Avenue
Cincinnati 6, Ohio

Dear Sir:

Mr. Burns, Executive Secretary of the Michigan State Medical Society, kindly forwarded to me your letter regarding a General Practice organization in Michigan.

We have no organization as such that I know of, but the by-laws of our State Society provide for a section for General Practice having the same rights and privileges as the sections on Surgery, Medicine, Urology, et cetera. The Wayne County Medical Society has a section on General Practice in the same manner, its chairman having a seat on the Society Council. A

CORRESPONDENCE

number of our hospital staffs also have a section on General Practice composed of general practitioners who have proved, by years of service on the courtesy or auxiliary staffs of these hospitals, that they are interested in promoting the welfare of such a hospital. As members of the staff they are eligible for all the privileges of the other staff sections, have a vote in staff management and the rules and regulations formulated by the staff.

An effort has been made by both the State and the Wayne County groups to force the American Medical Association to form a section on General Practice in that organization, but so far any such action has been referred to committees and died. In the meantime the same organization has put their O.K. on a section for medical students and for one on Physio-therapy. But the general practitioner who composes eighty per cent of their membership apparently isn't worthy. We in Michigan had a political scheme to force the issue this year, but the cancellation of the AMA meeting stopped us.

I personally believe that the formation of a General Practice Section in your County and State Societies and on the staffs of your larger hospitals is the best approach to an organization for general practitioners. The biggest drawback we have is the lack of interest shown by the general practitioners themselves. They are always too busy to bother with their own interests, but

the medical and surgical specialists always find time to make rules and regulations for their own sections and for the general practitioners as well.

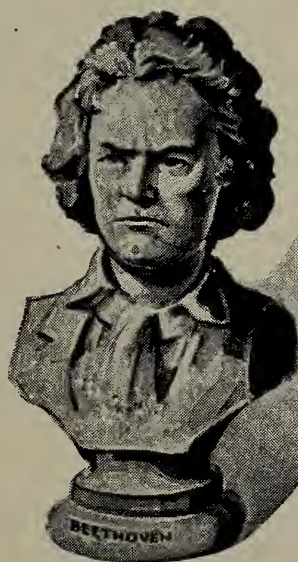
I hope I have been able to give you some information and that the Cincinnati and Ohio Societies will recognize, through your efforts, General Practice sections to their present setups and that we will be able to have other hospital staffs include such sections to their staffs. It is for the good of medicine and the medical profession and it may awaken that large sleeping group of medical men who wander through life accepting the status quo and doing their griping behind closed doors where it is to no avail.

Very truly yours,
W. B. HARM, M.D., *Chairman*
General Practice Section
Michigan State Medical Society

Dear Doctor Brunk and Members of Michigan State Medical Society:

Your most informative letter enumerating the various plans for our postwar education has arrived and following your suggestion that you would appreciate hearing from all of us, I am writing to thank you for the information and for all the effort you are putting forth

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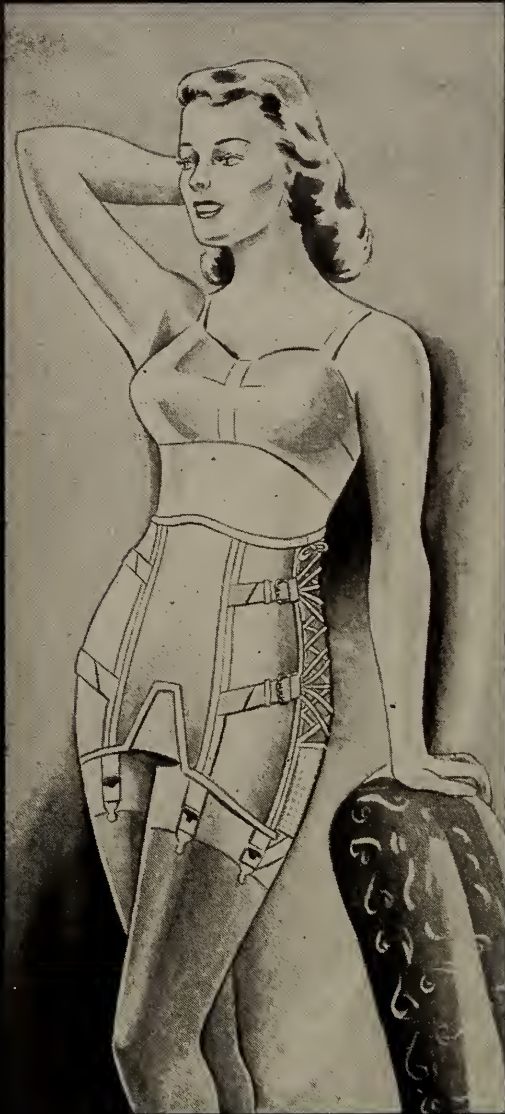
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on our behalf. It is indeed encouraging to know that you are so solidly behind us, looking after our interests on the home front while we're away, waiving our dues for the duration and, finally, forming such elaborate programs for our rehabilitation into the private practice of medicine.

We who have served in the armed forces have had an unique experience in that we have had a goodly taste of regimentation of our lives and have at the same time seen what federalized medicine can do to individual initiative. Frankly, I am very disillusioned and would no longer remain a practitioner in our chosen profession were this to be my lot in the years to come. Anything our Society can do for its members without the aid of federal funds will help to circumvent such a possibility and personally I'd rather pay the cost of my postgraduate education out of my own pocket than to accept it from the politicians. Were it necessary for some of us to secure temporary loans, I should think our Society should make its own provisions at a moderate rate of interest to handle them.

As for relocation plans, we older men have not given this phase of our return much consideration because our homes and families are by this time pretty firmly established in our respective communities and it would be difficult to break away from them. Most of us have evolved a new philosophy of life wherein we feel happiness is far more important than the economic phase of practice so perhaps some of us may be willing to leave the larger cities so as to seek out a new spot where we can enjoy the remaining years allotted us. Your guidance in this respect will be most helpful.

Being justly proud of the Michigan State Medical Society I have shown your letter to the other medical officers of this hospital and all agree that you are doing a most commendable job for us, one that is practical and concrete and one to which none of their respective organizations have, as yet, given much consideration. I am proud to say that I am one of you and am 100% behind you as you are behind me. I enjoy THE JOURNAL not only for its scientific articles but also for its information concerning your varied activities and news of local interest. Waiver of our dues while in service is just another indication to us of your appreciation of our efforts, no matter how great or small, towards bringing this gigantic struggle to a successful conclusion for the allied nations.

Faternally yours,

Major, Medical Corps, Army

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PUBLICATION COMMITTEE,
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MSMS ROSTER—SUPPLEMENTAL LIST

Bay County

William Kerr (E) Bay City
We regret this was omitted in the July issue.

Oakland County

McClure, Mary Arlene..... Pontiac

Wayne County

Angel, John Jos..... Detroit
Burnham, Frederick Detroit
Bogue, Robert E..... Detroit
Cantor, Meyer O..... Detroit
Condon, Stanley Detroit
Freeman, Benjamin Detroit
Goff, Milton G..... Detroit
Hiebert, E. Hobart..... Detroit
Holcomb, Clayton E..... Detroit
Jarembowski, Francis B..... Detroit
Koran, Valentine L..... Detroit
Melnik, Maxim P..... Detroit
Morrison, G. W..... Detroit
McFadyen, Hugh..... Detroit
Reed, E. Hobart..... Detroit
Shankwiler, Reed A..... Detroit
Szilagyi, D. Emerick..... Detroit
Thomas, Delma F..... Detroit
Van Bacelaere, Lawrence..... Ecorse

Washtenaw County

Miller, James W..... Ann Arbor

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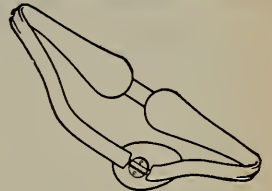
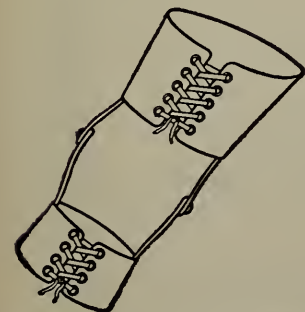
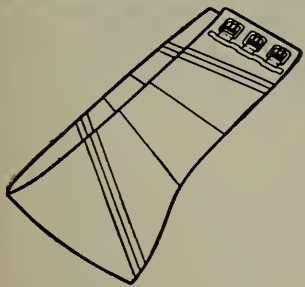
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* * *

Opportunities

Ten one-year fellowships in Psychiatry are available at the University of Michigan. Each will offer an annual stipend of \$2,000. These fellowships are under the aegis of the Office of Veterans Affairs of the State of Michigan. Appointees will be trained at the Neuropsychiatric Institute of the University of Michigan. Candidates must be graduates of a Class A Medical School, and must complete a rotating internship before beginning their fellowship. Applications should be made to Raymond W. Waggoner, M.D., Professor of Psychiatry, University Hospital, Ann Arbor, Michigan.

* * *

The University of Pittsburgh School of Medicine offers an orientation course in Clinical Allergy, under the

sponsorship of the American Academy of Allergy, for five days beginning October 1, at the school in Pittsburgh. Fee \$40.00 (only \$10.00 to veterans, servicemen, residents). Address inquiries to William S. McEllroy, M.D., Dean, School of Medicine, Bayard Street, Pittsburgh 13, Pa.

* * *

The American Board of Ophthalmology will hold its next examination in Chicago, January 18 through 22 (no examinations in October, 1945, as originally scheduled).

* * *

Polio Consultation Service.—The Michigan Crippled Children Commission, in co-operation with the Michigan State Medical Society, again offers pediatric and orthopedic consultation in suspected or established cases of poliomyelitis in children from birth to twenty years of age, inclusive, where the family is financially unable to provide the service and where such consultation service is not furnished locally. Physicians desiring this consultation should get in touch with the Secretary of the county medical society or with the full-time city, county or district health officer and supply him with information re the need and type of consultation, and his choice of consultants from the approved list of consultants in

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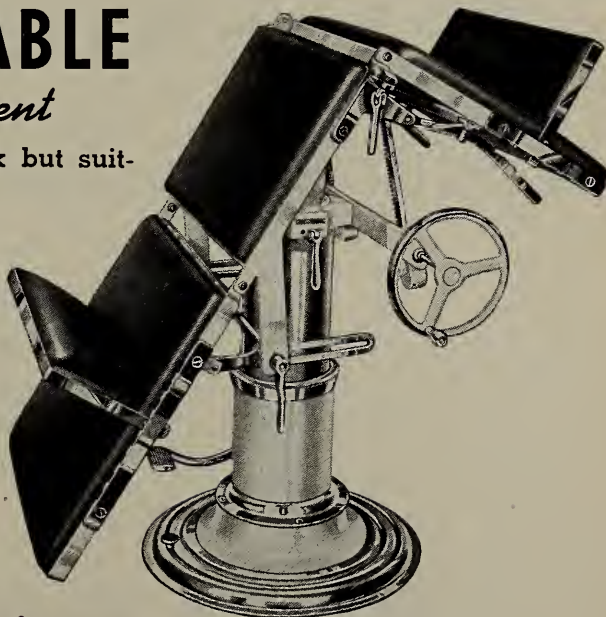
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his area. The Secretary of the county society, or the health officer, will telegraph the Crippled Children Commission (420 Hollister Bldg., Lansing) giving the name of the family physician, name of selected consultant, and name of patient. Upon receipt of such information, the Commission will wire direct to the consultant, authorizing the consultation service.

* * *

New Bills in Congress

A bill to permit the use of civilian hospitals for emergency hospitalization of veterans has been introduced into the U. S. Congress by Mr. Rogers of Oregon (H.R. 3594). Veterans' facilities may not always be within easy reach and if H.R. 3594 were passed by Congress, this would authorize use of a civilian hospital.

* * *

Senator Green of Rhode Island has introduced a bill (S. 1188) to amend and extend the Social Security Act. One amendment would set aside 1% of payrolls for hospital care either directly or through private organizations already in the field (such as Blue Cross).

Another proposal would make the Federal Government match state payments to persons temporarily unable to work, similar to Rhode Island's plan of sickness insurance.

* * *

A Tip

"Some druggists fill telephone prescriptions for narcotics and later take the prescriptions to the doctor for

his signature. It also appears that an unnecessarily large quantity of narcotics is being dispensed by some druggists and physicians to persons who are well known addicts. . . . it has been stated in defense of this condition that the doctors are overworked and prescriptions by telephone are timesavers. We are conscious of the overworked condition of most of our physicians, but we disagree with the contention that such practice is warranted in order to save time. It is a matter of obeying or violating the law."

—Extract from report of Federal Grand Jury, Muskogee, Oklahoma, June 26, 1945.

* * *

Good Reading

Congratulations to Mary Burchard Spahr, M.D., a practicing pediatrician of Ithaca, New York, who has written a highly intelligent and practical critique of the Wagner-Murray-Dingell proposal in the *Saturday Evening Post* of July 21. Dr. Spahr bases her criticism and analysis of the federal bill on her own experience with a personally conducted insurance program.

* * *

"German Doctors Under Nazism" is the title of an excellent editorial which was published in *Collier's* of August 4, 1945. (See page 898, this issue JMSMS.)

The final paragraph is freighted with important meaning:

"The lesson in the German experience seems clear enough. It is that there is no substitute for a free, bold and inquisitive medical profession, or for gen-

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erously financed and expertly staffed medical research, carried on year in and year out. It is devoutly to be hoped that the lesson of the German medical collapse will not be lost on us."

* * *

"Socialized medicine" is the subject of an excellent study contained in the summer issue of *The Index*, a fine brochure published quarterly by the New York Trust Company, New York City. Its concluding paragraph is as follows:

"Certain significant facts emerge from the violent controversial discussions surrounding the above questions. (Socialized medicine.) Voluntary efforts are presently getting into their real stride. They have not proved to be a drag on the country's high quality of medical proficiency or the brilliant progress made in research. By expanding and improving our public health service, by supporting various groups and community systems, and by encouraging private insurance companies to add to the usefulness of their services, the country should find that federal control of medicine is not necessary to insure a healthy nation. . . . Historically the experience of foreign countries provides no evidence to the contrary."

* * *

Ralph Robey, in presenting in *Newsweek* a report on an enormous program of government expenditures and expansion of government activities planned by certain "thinkers" in Washington, D. C., stated:

"Do not expect this program ever to be presented as a whole for consideration by Congress. It will be brought out part by part, each apparently designed mere-

SEPTEMBER, 1945

ly to meet a particular problem of pressing proportions. And every part will be carefully labeled with an innocuous name and wrapped around and around with beautiful and innocent-sounding names especially prepared to cover up the real purpose and intent of the proposal.

"So if you happen to be a believer in individual enterprise and freedom, watch for the component parts of this program. And don't be misled by someone's telling you that we are just taking a small step toward 'industrial democracy' or a 'planned economy.' Rather, remember that this same program when it was in effect in Italy was known as 'Fascism.' And today in Germany it goes under the name of 'Nazism.'"

In the medical field, the EMIC program fits into this description very nicely!

* * *

Socio-Economic

Estimated social security costs in ten years and in thirty-five years.—Professor I. J. Sollenberger, Head of the Department of Finance, University of Oklahoma, has completed a study entitled "Estimated Ultimate Cost of the Federal Old Age and Survivors Insurance" for the Research Council for Economic Security, Chicago. The author estimates the cost of the present program will be \$893,000,000 under the low and \$1,171,000,000 under the high assumption, both for 1955. For 1980, the low assumption on a level wage is estimated at \$2,625,000,000 and the high at \$3,958,000,000, which would be equivalent to 7.29 and 6.94 per cent of payroll, respectively. With some of the proposed expansions of the Social Security Act (excluding medical care, however) Professor Sollenberger estimates that the cost of

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these changes as of 1980 under the level wage assumption at a low will be \$5,614,000,000 or 10.78 per cent of payroll, and a high of \$7,476,000,000 or 9.12 per cent of payroll. Can the national economy carry such a large financial burden? Will over 10% of the nation's payroll, frozen in a dead fund, be out of all proportion to the nation's ability to shoulder?

* * *

Economic Blue Print for Postwar.—The January issue of *Fortune* magazine has presented the following statistical data:

It has been estimated that an annual production of 165 billion dollars of goods and services will be required after the war, if the country keeps 52 million persons at work, 3.5 million in the armed forces, and has not more than 4 million of unemployed.

TOTAL U. S. PRODUCTION OF GOODS AND SERVICES (1943 PRICES)

(In Billions of Dollars)

	1939	1943	1947
Federal Government	8.4	93.8	22.0
State and Local Government	8.5	6.8	8.0
Sub-total of Government	16.9	100.6	30.0
Business Capital Formation	10.4	.4	19.0
New Homes	2.5	.6	8.0
Transportation	2.6	3.5	3.0
Recreation	1.8	2.8	3.0
Medical Care	2.8	3.5	4.0
House Furnishings	3.7	3.8	6.0
Automobiles and Accessories	3.4	.5	7.0
Home Rents and Upkeep	7.2	8.0	9.0
Clothing, Shoes, etc.	8.7	12.4	13.0
Miscellaneous Consumer Needs	19.7	22.6	26.0
Foods, Beverages, Tobacco	28.3	34.1	37.0
Total National Production	108.0	192.0	165.0

DISTRIBUTION OF INCOME FROM PRODUCTION (1943 PRICES)

(In Billions of Dollars)

	1939	1943	1947
Business Depreciation and Depletion ...	6.1	10.4	10.0
Federal Corporate Income Taxes	1.6	14.4	5.0
Other Business Taxes	7.8	13.6	12.0
Interest Payment—Federal Debt9	2.5	4.0
Other Interest and Rent Payments	6.5	7.3	7.0
Undistributed Profits4	4.8	4.0
Dividends	3.8	4.1	5.0
Farmers	4.3	12.0	12.0
Professionals—Self-employed	6.9	11.3	12.0
Salaries and Wages	48.0	111.6	94.0
Total	86.3	192.0	165.0

(1943 Prices108.0)

* * *

Re the Military

Lt. Col. Hardy A. Kemp, Secretary of the Army Medical School in Washington and former dean of the College of Medicine at Ohio State University, has been appointed dean of the Wayne University College of Medicine. Dr. Kemp will assume his duties at the medical school, Detroit, as soon as he is released by the Army. Dr. Kemp is a graduate of St. Louis University, a specialist in bacteriology and preventive medicine, and now serves as the Army's executive officer in tropical medicine. He has been a member of the Army Medical Corps since February, 1942.

* * *

Major Kenneth B. Babcock, M.C., U.S.A., has been awarded the Bronze Star Medal "for meritorious service in support of combat operations in North Africa, Corsica and Italy, from June 1, 1943 to May 2, 1945."

Major Babcock established and efficiently operated a 100-bed hospital in the Anglo-Egyptian Sudan, and later

Quality carries on



skillfully directed 100-bed hospitals in Libya, Corsica and Italy in climate and terrain varying from the blazing deserts of Africa to the cold, mountainous regions of Italy.

* * *

Comdr. W. C. Ellet, M.C., USNR, of Benton Harbor, the first of that city's Doctors of Medicine to enter military service, was the first medical man to return to practice, as of August 1.

Commander Ellet has served over four years, since April, 1941, eight months before Pearl Harbor. As mayor of Benton Harbor, he was the first man in that position to join the colors in this war.

* * *

Capt. Hackley E. Woodford, M.C., has returned to practice in Benton Harbor after thirty-two months' service in the Army Air Corps.

* * *

Priority to Vets.—Of interest to medical officers who will be separated from the armed forces are new regulations recently issued by the Surplus Property Board. Regulation No. 7 provides that veterans may apply to the Smaller War Plants Corporation in their district for authority to purchase surplus medical equipment. First priority goes to veterans. Property up to the value of \$2,500 may be purchased through the SWPC with payments distributed over a five-year period.

* * *

"Information Bulletin for Medical Officers" has been issued by the Bureau of Information of the American

Medical Association. Full facts on what is available to returning medical veterans from the GI Bill of Rights, et cetera, is indicated in this informative brochure. Copies may be obtained free by writing Lt. Colonel Robert D. Bickel, M.C., at 535 North Dearborn Street, Chicago 10, Illinois.

* * *

Organization

The Wayne County Medical Society, Detroit, has appointed a special committee for the creation of better public relations, to be known as the "Press Committee."

All calls from newspapers are to come to the Executive Secretary who shall refer them to the appropriate scientific section chairman, and if not available, to the chairman of the Press Committee. The Committee members are permitted to be quoted per their official capacity (such as "Editor of the *Detroit Medical News*," et cetera.) General rules under which this committee is to operate and the mechanics of news releases are to be worked out by the Committee as a whole.

* * *

The New England States have formed a "New England Medical Council" of the medical societies of that area for the purpose of discussing mutual problems. James R. Miller, M.D., Hartford, Chairman of The Council, Connecticut State Medical Society, was elected President; John F. Kenney, M.D., President of the Rhode Island Medical Society, was chosen as Vice-President; and John E. Farrell, of Providence, Rhode

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GYNECOLOGY—Two-week Intensive Course, October 22. One-week Personal Course in Vaginal Approach to Pelvic Surgery, September 17.

OBSTETRICS—Two-week Intensive Course, October 8.

ANESTHESIA—Two-week Course in Regional, Intravenous and Caudal Anesthesia.

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Island's Executive Secretary, was elected Secretary-Treasurer of the new organization.

* * *

Miscellaneous

State and County Medical Society dues are deductible in your income tax report. From a tax standpoint, your County and State Medical Society dues and assessments are an asset. They are deductible in your income tax report. Knowing this, one physician recently stated: "I wish the dues were ten times greater than they are, first, because I could use the deduction in my income tax, and secondly, because the medical profession needs a stronger bank of protection in these fearful times."

* * *

Help conserve nursing personnel. Even though the Army is no longer actively recruiting nurses, a dire shortage of nurses for civilian service continues. The National Nursing Council for War Service requests the continued assistance of the medical profession in helping towards the best possible distribution of available nursing care and in conserving nursing personnel (a) by limiting nurses to patients who actually need them; (b) by locating inactive or retired nurses and inducing them to return to active service; (c) by urging nurses now doing less important work to take more essential positions.

* * *

New Michigan Adoption Law.—Public Act 234 of 1945, which took effect September 6, 1945, gives greater protection to families desiring to adopt a child, aims at safeguarding the rights of children involved in adoption procedure, and places increased responsibility with the probate court.

The new adoption law prescribes a year's waiting period before an order of adoption can be entered, unless the child's best interests are served by a waiver of such waiting period.

The new law also requires supervision of the adoptive home during the waiting period. It prohibits the placement of any child in an adopted home unless parental rights are terminated and the child is made a ward of the court.

The law also prohibits the exchange of money or other consideration of value in connection with the adoption of a child, except for charges and fees approved by the probate court.

* * *

Respirators

With the approach of the poliomyelitis season, the National Foundation for Infantile Paralysis has again issued a booklet (No. 24C-120 Broadway, New York) giving the location and ownership of all registered adult respirators in the United States, as of May 1, 1945. In Michigan are listed:

Ann Arbor	University Hospital (2)
Battle Creek	Community Hospital
	Leila Hospital
	Percy Jones Hospital (USA)
Benton Harbor	Mercy Hospital
Cadillac	Mercy Hospital

Dearborn	Junior Chamber of Commerce
Detroit	Children's Hospital
	Henry Ford Hospital
	Herman Kiefer Hospital (6)
Eloise	Wayne County Supt. of the Poor
Flint	Hurley Hospital
Grand Rapids	Blodget Memorial Hospital
	Butterworth Hospital
Hancock	St. Joseph's Hospital
Iron Mountain	Iron Mountain General Hospital
Ironwood	Grand View Hospital
Jackson	W. A. Foote Memorial Hospital
	Jackson County Sanatorium
Kalamazoo	Borgess Hospital
Lansing	Lansing City Hospital (2)
Marquette	Michigan Children's Clinic
	Chicago and N. W. Ry.
	St. Luke's Hospital (3)
Muskegon	Muskegon County Medical Society
Paw Paw	Van Buren County Supervisors
Pontiac	Oakland County Contagious Hospital
Port Huron	Port Huron Hospital
Saginaw	Saginaw County Hospital
	St. Mary's Hospital
South Haven	South Haven Hospital
Traverse City	James Decker Munson Hospital

Paper Published

"A Thoracic Binder," by Edward F. Skinner, M.D., of the Herman Kiefer Hospital, was published in *The Journal of Thoracic Surgery*, St. Louis, April, 1945.

Central Michigan Medical Conference

The Central Michigan Medical Conference held at Traverse City, July 26 and 27, 1945, presented an extraordinary program and had a very good audience interest. The attendance was good, many of the doctors staying over night, others driving back and forth.

There were surgical clinics and demonstrations, and medical clinics held all day Friday. This was quite an innovation; they were very well attended, and much favorable comment resulted. Both Drs. Barker and Riecker were highly pleased with this as a teaching program. Quite a variety of cases were presented, most of them fairly well worked up in advance. Suggestions as to additional procedures and therapeutic measures were given, and much general discussion took place.

The public testimonial dinner Friday evening was attended by about 175 people. This was an example of exceptional public relations. Vocal honors were heaped upon the staff of the University Hospital and upon the local medical profession. Senator James Milliken spoke about the proposed addition to the J. D. Munson Hospital and its place as a teaching center for the profession of the whole upper half of the lower peninsula.

The formal program of Thursday was:

CARL BADGLEY, M.D.—"Some Interesting Lesions of the Carpals."

PAUL BARKER, M.D.—"Hypertension."

FREDERICK A. COLLIER, M.D.—"Early Ambulant Follow-up Operation."

SEPTEMBER, 1945

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HERMAN RIECKER, M.D.—“Diarrhea in Adults.”
JAMES L. WILSON, M.D.—“A Concept of the Etiology of Congenital Deformities.”
NORMAN F. MILLER, M.D.—“Endometriosis.”
RALPH O. RYCHENER, Memphis, Tenn.—“Kodachrome Presentation of Common Diseases of the Eye.”
Seventy-three doctors registered at the meeting.

* * *

Michigan Mental Health Board

The Michigan Mental Health Commission and the Governor have designated William J. Norton of Detroit, Raymond W. Waggoner, M.D., of Ann Arbor, and Harry B. Zemmer, M.D., of Lapeer, to outline the work of the commission. They, with Mrs. Carl F. Blankenburg of Kalamazoo and Edward Bilitzke of West Branch, constitute the Board.

The Director will be a Michigan physician of at least ten years' experience as a psychiatrist. The eleven superintendents of state hospitals for mental diseases will assist the committee in preparing the outline of activities of the new commission.

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

RYPINS' MEDICAL LICENSURE EXAMINATIONS, Topical Summaries, Questions and Answers. Fifth enlarged edition, completely revised under the editorial direction of Walter L. Biering, M.D., F.A.C.S., M.R.C.P., Edin. (Hon.); Member National Board of Medical Examiners; Secretary, Federation of State Medical Boards of the United States: With the Collaboration of a Review Panel. Philadelphia: J. B. Lippincott Company, 1945. Price \$6.00.

Since 1933 five editions of this volume have appeared. Examinations for Medical Licensure follow mostly a well-arranged plan. The questions have been studied for the past few years. New fields and thoughts have been incorporated. The authors have been assigned a field of study such as Chemistry, Anatomy and Physiology, Obstetrics and Gynecology and have written a concise short text covering in sufficient but not too much detail the material surveyed by the questions in that field. It is not a question and answer compendium, but a text outlining the subject. Each chapter is followed by a set of typical questions. The book is not a satisfactory text for first study of the subject, but is a good review.

For the student, or practitioner contemplating taking State or National Board Examinations it is a valuable, worth-while outline to study.

THE PSYCHOLOGY OF WOMEN. A Psychoanalytic Interpretation. By Helene Deutsch, M.D., Associate Psychiatrist, Massachusetts General Hospital, Boston Psychiatric Institute. Volume Two. **MOTHERHOOD**. New York: Grune & Stratton, 1945. Price \$5.00.

In her second volume, Dr. Deutsch has shown the same depth of observation, the same yen for knowledge, the same inexhaustible detail that marked the first. The case histories could only be written from a personal and intimate knowledge of the patient, and they represent hours spent delving into most minute facts bearing on the patients' problems. This wealth of detail is carefully marshalled to give accurate data upon which to draw conclusions and make diagnoses.

This volume on Motherhood expounds the slightest secret aspirations, acts, or wishes during the whole process leading to motherhood. It discusses the Mother-Child relation and has some rather valuable suggestions. It also recognizes the present upset world and gives an insight into the life and problems of the unwed mother and adoptive mothers.

For the psychiatrist this book is a treasure trove.

MEN UNDER STRESS, By Lt. Col. Roy G. Grinker, M.C., Army Air Forces; formerly Fellow of the Rockefeller Foundation and Chairman of the Department of Neuropsychiatry, Michael Reese Hospital, Chicago; and Major John P. Spiegel, M.C., Army Air Forces, formerly of the Department of Psychiatry, Michael Reese Hospital, Chicago. Philadelphia: The Blakiston Company, 1945. Price \$5.00.

Combat air force men have been studied in their reactions to combat, and to relief periods. Their emo-

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tions have been catalogued and their reactions predicted under hypothetical conditions, but conditions that are sure to come. The motivation for combat is real, not glowing theories. Most fight to get back home, not for some high-sounding catch phrase. Contrary to radio commentators the combat team would rather not be "in there fighting like demons." Many worry about what they will find at home—some were just married and not adjusted. What will they find—a true wife or another's children? What do they deserve—have they been true?

Sometimes there is worry over a possible dereliction that may have been partly responsible for a comrade's injury—a feeling of guilt.

This book is full of analyses of every imaginable thought or situation. It is simply written, avoiding scientific words. The story can be easily understood—and while written about Air Force men could apply to any returning combat soldier.

Interesting and authoritative—the methods and lessons learned may be carried into civil practice.

The book is not too long and is challenging.

COMMON AILMENTS OF MAN. Edited by Morris Fishbein, M.D., Editor of *Hygeia*, the Health Magazine, Garden City, New York: Garden City Publishing Co., Inc., 1945. Price \$1.00.

This is another volume about medical topics written by doctors for lay people, first appearing in *Hygeia*. The articles are short, authoritative and contain good advice about treatment, but no prescriptions. Physical means, surgery where needed, etc., are suggested. Such subjects as: headaches, neuritis, high and low blood pressure, athlete's foot, arthritis, or rheumatism are discussed. The book is valuable in these days of shortage of Doctors as capable of allaying the fears of some of our two sensitive patients with hundreds of questions.

RADIOLOGIC EXAMINATION OF THE SMALL INTESTINE. By Ross Golden, M.D., Professor of Radiology, College of Physicians and Surgeons, Columbia University; Director of the Radiological Service, The Presbyterian Hospital, New York. With Illustrations of 183 Subjects in 75 Figures. Philadelphia: J. B. Lippincott Company, 1945. Price \$6.00.

This monograph is of a size easily handled, the type is large, and readable, excellent spacing of the lines. The illustrations have been well selected, and excellently reproduced.

Dr. Golden, more than any other one man, has brought to the attention of the medical profession the importance of detailed study of the small intestine. He has developed a method which, in his capable hands, gives almost unbelievable results. By virtue of his long, careful, scientific study, he has contributed to our knowledge of the small intestine much as the late Russell Carmen did to our knowledge of the gastrointestinal tract as a whole.

The material presented in this book has been well arranged, and the subject covered from all aspects; a glance at the table of contents shows the scope. Because of the character of the book, emphasis has been

placed upon the radiologic aspect, yet there is much valuable material present for both the general practitioner and the surgeon. The chapter on the Miller-Abbott tube is extremely thorough. The importance of the long tube has been recognized and well established, though in several parts of the country it has more or less fallen into disrepute because of the individual inability to handle this tool. Religious adherence to the principles advocated by Dr. Golden in this chapter will pay dividends to those having need of intestinal intubation.

By focusing attention on one chapter in particular we do not mean to belittle the remainder of this volume. The newer concepts of the small intestinal physiology and nervous innervation are discussed. Differences between infant and adult intestinal patterns are demonstrated and explained. Specific organic lesions come in for their share of attention, under separate chapter headings.

To me this is one of the most important monographs to come out in radiological literature since "The Lung" by Edgar Snow Miller.

G.T.P.

TECHNICAL METHODS FOR THE TECHNICIAN. By Anson Lee Brown, A.B., M.D., Director of Dr. Brown's Clinical Laboratory and Dr. Brown's School for Technicians, Columbus, Ohio. Published by The Author. Columbus: B-B Printing Co., 1944. Price \$10.00.

Laboratory technique to be of value must be exact, accurate, promptly done and just as promptly and accurately reported. This book has all the tests given in step-by-step method, well illustrated and plainly written. Dr. Brown has an almost paternal style and talks to his students as if they were his children.

We unqualifiedly recommend this text as up to date and reliable.

PSYCHIATRY IN MODERN WARFARE. By Edward A. Strecker, A.M., M.D., Litt.D., LL.D., Professor of Psychiatry and Chairman of the Department, School of Medicine, University of Pennsylvania. Consultant for the Secretary of War to the Surgeon-General of the Army and the Army Air Forces; Consultant to the Surgeon-General of the Navy; Consultant to the Surgeon-General, U.S.P.H.S.; and Kenneth E. Appel, Ph.D., M.D., Sc.D., Assistant Professor of Psychiatry and Chief of Clinic, School of Medicine, University of Pennsylvania; Lecturer in Psychiatry, School of Neuropsychiatry; Medical Examiner for the Armed Forces Induction Station, Philadelphia. Sometime Visiting Psychiatrist, Auspices Rockefeller Foundation, Eighth Service Command, U.S.A. New York: The Macmillan Co., 1945. Price \$1.50.

The neuropsychiatric lessons of the first World War were too lightly regarded. The conditions of this war would be vastly different. Some believed there would be few beds needed for neuropsychiatric cases. The head of the department with responsibilities for the mental health of over 7,000,000 men was a Colonel and the facilities entirely inadequate. Neuropsychiatric discharges in World War I were 7/10 per cent. In this war they have reached 50 per cent in some instances. This brochure discusses the incidence of psychiatry, demobilization and methods of helping returning servicemen.

SEPTEMBER, 1945

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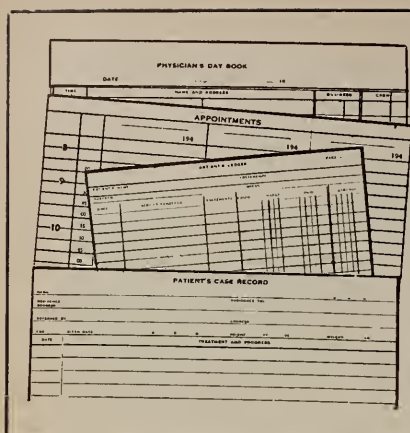
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REFRACTION OF THE EYE. By Alfred Cowan, M.D., Professor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania; Attending Ophthalmologist, Philadelphia General Hospital; Consulting Ophthalmologist, Council for the Blind, and Supervising Ophthalmologist of the Department of Assistance, Commonwealth of Pennsylvania. Second Edition thoroughly revised. Illustrated with 172 engravings and 3 colored plates. Philadelphia: Lea & Febiger, 1945. Price \$4.75.

Scientific refraction demands much more knowledge than lens strength and combination. This book gives the basic theory and physics of optics, the types of lenses, materials and formulas for studying and using the foci, conjugate foci, optical center, convex and concave lenses. All are illustrated and formulas are given. The complicated facts of optics are explained. The act of refraction of the patient is described with analysis of findings and the writing of the prescription. Contact and telescopic lenses are described and their use indicated. This book is a compendium of all the things one should know about glasses and their use—and is good reading.

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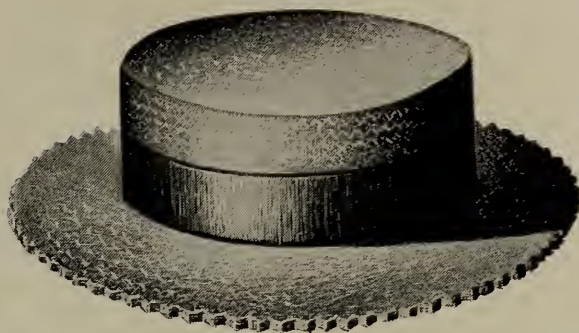
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Threefold Postgraduate Program for Michigan's Medical Veterans

Prior to World War II, the health needs of the people of Michigan were provided by approximately 5,100 practitioners of medicine. Now 2,287 of these doctors of medicine are absent from the State serving their country in the armed forces of the United States. The result is that a definite hardship has been thrust upon the public which is suffering from the acute shortage of medical care.

A high percentage of the medical veterans of Michigan have been out of contact with civilian practice for periods varying from six months to five years; many have been placed in administrative posts and have not enjoyed any type of medical experience while in Service. These medical veterans feel the need for postgraduate or continuation courses of short duration so that they may better serve the public upon their return to their own homes. A recent survey indicates that 81.3 per cent of medical veterans—or 1,860 Michigan doctors—state that they will need postgraduate work or review courses before they resume civilian practice.

The State of Michigan has spent and is spending large sums of money for preventive medicine, for public health, and for its bacteriological laboratories. In order to maintain that program and protect the State's investment, it is necessary to have a well-informed and alert medical profession. The general practitioner in every community of this State is the man around whom all these preventive and public health programs are built. The greater his efficiency, the better the investment of the State is protected.

To insure the best medical care for the people of Michigan and to serve our medical veterans, postgraduate courses have been provided by the University of Michigan Medical School and Wayne University College of Medicine, which have expanded their existing facilities to the limit in an attempt to meet the needs. Despite the augmented programs, the facilities at the two medical schools of Michigan still are inadequate to meet the great demand by medical veterans for continuation study. So a course has

been developed at Wm. J. Seymour Hospital at Eloise, and is proposed as a new project.

Eloise has been selected because of its vast wealth of untouched clinical material, because of its geographical location in relation to the two medical schools in this state with which it will co-operate in this educational project, and because it is strategically located in relation to the medical population of the State.

Of the three projects, the two at the University of Michigan and at Wayne University have been in operation for a number of years and are financed. However, the project at Eloise, arranged primarily for returning veterans who were general practitioners from all parts of the State, is a new project and needs financing. The budget, to insure the inauguration and maintenance for the next year of this important training center for Michigan's medical veterans, totals \$25,876.00.

When provided, this project at Eloise will complete a well-rounded program of postgraduate medical education which will give the Michigan medical veteran what he needs to assume his place in the ranks of our up-to-date practitioners on the Michigan home front.

Since this project will be of inestimable value to the State of Michigan in that it will increase the level of practice which doctors of medicine will be able to render the people in their home communities, the Michigan State Medical Society has requested the State Administrative Board to favorably consider the project and to finance it out of the moneys allocated for aid to veterans of World War II.

AMA HOUSE OF DELEGATES TO CONVENE IN CHICAGO, DECEMBER 3

The annual meeting of the House of Delegates, the policy-making body of the American Medical Association, will be held in Chicago for four days, beginning December 3.

Because of the war, the annual AMA convention could not be held in New York this year. A wartime session, attended by more than 7,000, was held in Chicago last year. San Francisco was elected some years ago to play host to the June, 1946, convention.



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Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods, American Medical Association.

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AVAILABLE in
packages of 24 tablets,
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IMPORTANT: Please note that
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" . . . topical application insures drug concentration to a degree not attainable by other routes of administration, a point which places sulfonamide therapy by means of chewing vehicles, as discussed by Pfeiffer and Holland, on a logical basis."

— Editorial: Naval Med. Bulletin,
(April) 1945, p. 862.

the site of oropharyngeal infections

White's SULFATHIAZOLE GUM*

provides an efficient and practical method of effecting *immediate* and *prolonged* topical chemotherapy in oropharyngeal areas not similarly reached with gargles, sprays or irrigations.

Even a single tablet chewed for *one-half to one hour* provides a salivary concentration of locally active sulfathiazole averaging 70 mg. per cent. Moreover, resultant blood levels of the drug, even with maximal dosage, are so low (rarely reaching 0.5 to 1 mg. per cent) that systemic toxic reactions are virtually obviated.

INDICATIONS: Local treatment of sulfon-

amide-susceptible infections of oropharyngeal areas: acute tonsillitis and pharyngitis—septic sore throat—infectious gingivitis and stomatitis—Vincent's infection. Also indicated in the prevention of local infection secondary to oral and pharyngeal surgery.

DOSAGE: One tablet chewed for *one-half to one hour* at intervals of one to four hours, depending upon the severity of the condition. If preferred, several tablets—rather than a single tablet—may be chewed *successively* during each dosage period without significantly increasing the amount of sulfathiazole systemically absorbed.

*A product of WHITE LABORATORIES, INC., Pharmaceutical Manufacturers, Newark 2, N. J.

Diagnostic Centers for Rheumatic Fever Control

Sponsored by the Michigan State Medical Society and the County Medical Society in whose area the project will be located, nine Diagnostic Centers are being organized in the cities of Ann Arbor, Bay City, Flint, Grand Rapids, Jackson, Kalamazoo, Lansing, Marquette, and Traverse City. These are in addition to the Cardiac Centers maintained in Detroit.

Fundamental rules for these Consultation and Diagnostic Centers have been developed by the MSMS Committee on Rheumatic Fever Control working with the Chairmen of the County Society Committees where centers will be established, as follows:

1. The work shall be limited to consultation and diagnostic service only.
2. All reports and recommendations shall go to a private doctor of medicine, on uniform blanks.
3. Indigents are the responsibility of the Michigan Crippled Children Commission. Private patients shall be charged a fee.
4. Reporting shall be made of all cases to the Michigan Department of Health on uniform blanks.
5. Uniform blanks shall be used by all Centers. Accurate records and follow-up reports shall be kept.
6. Definite follow-ups should be established (and be included among recommendations to the referring doctor of medicine).
7. The Centers must be in a hospital approved by the Michigan Crippled Children Commission.

A notice will be sent to all doctors in the areas indicated that they may send their cases to the Consultation and Diagnostic Center on the day chosen by the local Committee for the examinations. No treatment will be permitted in these Centers. No charge is made to indigents for consultation service, the Michigan Crippled Children Commission assuming the cost of these fees. In all these Centers the physician-patient relationship shall be maintained.

The MSMS Committee on Rheumatic Fever Control stressed that all treatment services are to be given by the family practitioner and that it is his responsibility to see that the prescribed treatment is carried out.

Notices of the opening of each Center, to be located usually at one of the city's hospitals, will be sent in each instance to the doctors of medicine located in that area.

The Michigan State Medical Society's organization of Diagnostic and Consultation Centers in Rheumatic Fever throughout the State, in co-operation with local medical societies, will help the medical profession in its efforts to stamp out the most insidious and greatest killer of little children.



for HEALTH

HOMES

HAPPINESS

Among the world's famous mineral waters, these have been renowned for over 80 years. Enjoy soothing baths in ideal surroundings... a city of delightful homes... only 30 miles from Detroit in the heart of Michigan's playground.

You'll find healthful climate, unusual recreational facilities, delightful vacation spots—all air-conditioned by the Great Lakes. Advantageous sites for industry and business also available.

ONE OF THE MOST FAMOUS SPAS IN THE WORLD!

Mount Clemens' famous mineral waters—flowing direct from the earth's depths—have been enjoyed by generations seeking rest, relaxation and convalescence. Analysis of waters gladly furnished to physicians on request.



Convenient Bus Service

Illustrated folder and mineral bath information. Write Room 113, Board of Commerce, Mount Clemens, Michigan.

Achievements For Tomorrow

• **CANCER** killed 163,000 people in the United States during 1942, it is estimated*, and ranks second in causes of deaths. The rate apparently is increasing. About 300,000 new cases are diagnosed for the first time each year and approximately 475,000 persons are under treatment at any given time.

Many cancer patients can be cured by surgery, X-ray or radium if the disease is diagnosed early enough. There is not, however, sufficient information about the cause of cancer and its characteristics to have led to the discovery of a specific and generally applicable cure. Physicians are helping by reporting their experiences and observations. What will be the cure? Who will discover it?

People should be educated to the necessity of having examinations at the first symptoms indicative of cancer so that such curative measures as are available may be utilized as quickly as possible. Too many hide their condition until a cure is impossible.

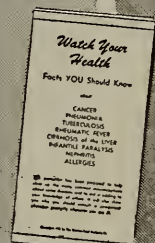
To aid in such educational work, we have prepared a pamphlet — "Watch Your Health" — in which simple facts about this and six other serious diseases are given. Copies for distribution to your patients are available on request.

*U. S. Summary of Vital Statistics, 1942

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You and Your Business

1946 ANNUAL SESSION IN DETROIT

The Michigan State Medical Society Annual Session of 1946 will be held at the Book-Cadillac Hotel, Detroit.

The House of Delegates will meet on Monday and Tuesday, September 23-24.

The Scientific Assemblies are scheduled for Wednesday, Thursday, Friday, September 25-26-27.

MSMS Radio Hours, WJR, Detroit
Fridays—6:30 p.m., E.S.T.

PAID ADVERTISING IN NEWSPAPERS

The MSMS Council recommends that county and district medical societies explore the possibilities and advantages of paid advertising in local newspapers, to aid the people to understand fully the real meaning and implications of the various congressional proposals for the socialization of medicine, as well as to stress the advantages of the physician-patient relationship, the private practice of medicine, and pre-pay medical service programs.

The Council recommends that the benefits of the American system of quality medical service be emphasized; that good medical care under the present type of voluntary enterprise will continue to improve its quality and distribution *if left unshackled and free.*

The public must be accurately informed; so county medical societies have been urged to investigate the cost of publication and—in co-operation with the advertising salesmen of your local newspapers—to *undertake to secure sponsors for this necessary advertising.*

INFORMATION BULLETIN FOR MEDICAL OFFICERS

Copies of this excellent Bulletin, giving physicians returning from the armed forces a concise statement of facilities and services now available to help them with their problems of licensure, relocation, further education, etc. (including digest of GI Bill of Rights), is available from the Bureau of Information, American Medical Association, 535 N. Dearborn, Chicago 10, Ill.

MICHIGAN'S GOVERNOR KELLY SEEKS EARLY RELEASE OF STATE'S DOCTORS FROM SERVICE

Governor Harry F. Kelly presented some startling facts to the Surgeons General of the Army and Navy and to Paul Barton, M.D., of the Office of Procurement and Assignment Service of the War Manpower Commission, in Washington, D. C., on September 14.

Eighty-eight communities in the State, some with populations of more than one thousand, have no doctors of medicine at all.

Michigan is shy 2,287 doctors on a peace-time health services basis.

In districts which still have doctors of medicine, the physicians are carrying a much heavier load because of the high percentage of medical men in the armed services (60,000 in the armed forces as against only 78,000 to care for civilian needs).

Michigan used to have one doctor to every 950 persons; today the ratio is one doctor to every 1,400.

Governor Kelly outlined to the Washington officials the struggle which has been carried on by the middle-aged and older physicians of the State who have remained on the home front doing two and three times their normal amount of work in order to bring needed health service to the people. "I do believe that in returning doctors to the States," Governor Kelly said, "every effort should be made by those in charge of demobilization to correct the deficiency of doctors in Michigan and to equalize our contribution proportionately with that of other States."

Governor Kelly was armed with a survey showing that many communities were depending on doctors well along in years, physicians who had voluntarily returned from semi and full retirement to help in the war emergency. Governor Kelly explained that these men, and all the civilian doctors in Michigan, had almost reached the end of their resources in energy and health, and unless immediate separations from military service were made, the health picture in Michigan would drop from its present high, satisfactory plane.

Governor Kelly is to be congratulated on his

(Continued on Page 1008)

ERTRON THERAPY now occupies a position of established importance among the measures routinely considered in the management of arthritis.

The cumulative evidence of several years in many series of cases reveals that Ertron therapy is followed by definite subjective and objective improvement in a high percentage of arthritic patients.

Objective improvement is manifest in decreased pain and soft tissue swelling. There is measurable increase in muscular strength and joint motility.

Subjectively, in undernourished patients, a systemic influence is reflected in increased appetite and consequent weight gain. *The Ertronized patient feels better and is better.*

The bibliographic background of Ertron is sufficient warrant of both its therapeutic efficacy and safety, when used according to established procedure. It is worthy of note that the reports in the literature refer only to Ertron, the product used in these clinical studies.

Ertron alone—and no other product—contains electrically activated vaporized ergosterol (Whittier Process).

Ertron is the registered trade-mark of Nutrition Research Laboratories

ERTRON PARENTERAL

For the physician who wishes to reinforce the routine oral administration of Ertron by intramuscular injection, Ertron Parenteral is available in



packages of six 1cc. ampules. Each ampule contains 500,000 U.S.P. units of electrically activated vaporized ergosterol (Whittier Process).

Supplied in bottles of 50, 100 and 500 capsules.

NUTRITION RESEARCH LABORATORIES • CHICAGO

MICHIGAN'S GOVERNOR KELLY SEEKS EARLY RELEASE OF STATE'S DOCTORS FROM SERVICE

(Continued from Page 1004)

knowledge of the critical situation and his courage in forcibly presenting the problem to those in the national capitol who are able to solve it.

MSMS Radio Hours, WJR, Detroit
Fridays—6:30 p.m., E.S.T.

THE INDIANA OUTLINE

The Drafting Panel of the Indiana State Medical Association met on June 17, 1945, and considered medical economic and legislative problems. The following conclusions were adopted by the Committee composed of President N. K. Forster, M.D., Hammond, Chairman; J. E. Ferrell, M.D., Fortville; H. G. Hamer, M.D., Indianapolis; C. H. McCaskey, M.D., Indianapolis; J. T. Oliphant, M.D., Farmersburg; F. T. Romberger, M.D., Lafayette, and J. William Wright, M.D., Indianapolis.

1. We are in favor of a medical-care program offering good medical care to *all* of the people based upon voluntary participation, both by the patient and the physician, and free from all administrative direction or control by governmental agencies or bureaus.

2. We are in favor of an indemnity plan as contrasted to a service plan, based on voluntary participation, with benefits paid directly to the individuals concerned.

3. We are in favor of a medical-care program which will have its inception in the various states and will be an equitable plan covering the needs of its residents. *Group co-operation*, on a national level, by these various state plans should be accomplished as soon as possible.

4. We are in favor of consumer subsidies for those in total or partial need of medical assistance, but only in so far as these grants are paid directly to the individuals concerned.

5. We are in favor of proper legislation which will direct the medical care of veterans to their own communities, with free choice of hospitals and doctors. This should be effective in relieving the government of the necessity for construction of large veterans' facilities, and find particular favor among the veterans themselves.

6. We are in favor of close unification of all opinions relative to medical care plans, simplification of objectives, and a well organized and united program to obviate any necessity for governmental intervention.

7. We are in favor of a broad educational program based upon co-operative meetings and discussions with teachers, ministers, industrialists, farmers, labor organizations and all professional and lay groups seeking a common level of understanding and solution of the problems affecting the public health.

8. We are in favor of an active participation, by the medical profession, in the administrative functions of hospitals to the end that medical practice shall be protected from the encroachment of hospital attempts to control or dictate medical practice, or to infringe thereon, and that a clear perspective may be had of the part hospitalization costs play in the total costs of medical care. In addition there must be some control of government appointments to hospitalized cases coming under their subsidies.

9. We are in favor of the establishment of a Secretary of Public Health and Welfare, of Cabinet rank, under whose supervision *all* related matters will be consolidated and administered and who shall be appointed from the ranks of *actively* practicing physicians.

10. We are in favor of the employment by the American Medical Association, of a prominent Lay figure in American life, at a substantial remuneration, to represent and speak for the American medical profession in *all* matters dealing with or bordering on public relations. His actions to be guided and assisted by a consulting body of the American Medical Association, but his actual representations to be determined by his own judgment.

11. We are in favor of complete and entire freedom from political domination of medical practice in any form and are thoroughly in accord with the basic principle of Americanism in initiative effort and accomplishment.

12. We are in favor of, and whole-heartedly endorse, the 14 points promulgated by the Council on Medical Service and Public Relations of the American Medical Association, and will support every effort to obtain legislation; to develop dissemination; to provide co-operation and to seek acceptance in order that the program may receive universal approval and application.

MSMS Radio Hours, WJR, Detroit
Fridays—6:30 p.m., E.S.T.

MICHIGAN MEDICAL SERVICE LEADS

The total number of subscribers enrolled with Michigan Medical Service as of July 31, 1945, was 836,734. During the seven-month period from January 1, 1945, to July 31, 1945, the doctors of Michigan were paid \$2,572,687.25 for services rendered to MMS subscribers.

In order to meet the demand for this service, group requirements have been lowered to five rather than ten employees. This will take care of those who are employed in small offices and business.

The Board is also considering community enrollment for the purpose of extending the coverage to those who do not have the opportunity to enroll in groups.

(Continued on Page 1010)



for **Infants and Children**

MILK DIFFUSIBLE *Vitamin D* PREPARATION

DRISDOL in Propylene Glycol makes it possible to secure the benefits obtainable from combining vitamin D with the daily milk ration. This preparation is simple, convenient and easy to use, and relatively little is required for prophylaxis and treatment of rickets—*only two drops daily.*

*does not float on milk
does not adhere to bottle
does not have a fishy taste or odor*



Drisdol in Propylene Glycol—10,000 units per Gram—is available in bottles containing 5 cc. and 50 cc. A special dropper delivering 250 U.S.P. vitamin D units per drop is supplied with each bottle.

WINTHROP CHEMICAL COMPANY, INC. NEW YORK 13, N. Y.
Pharmaceuticals of merit for the physician WINDSOR, ONT.

D*risdol in Propylene Glycol*

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Brand of
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CARE OF VETERAN IN HOME COMMUNITY

A plan of utilizing local practitioners for home and office treatment of veterans through Michigan Medical Service is under way. Several meetings have been held with representatives of the Veterans' Administration with a view to negotiating this plan, in order to provide the best type of medical and surgical care to the veteran in his home community by his own family physician—the doctor of his choice. This project is still in the negotiation stage. Progress will be reported to the membership either in *THE JOURNAL* or through the Secretary's Letter.

MSMS Radio Hours, WJR, Detroit
Fridays—6:30 p.m., E.S.T.

POINTS CUT FOR ARMY DOCTORS

The War Department announced on September 15 that the discharge point score and age requirements of Army medical personnel had been reduced in order to return 13,000 doctors of medicine to civilian life by the end of 1945. Many other Army medical officers will be affected.

By July, 1946, when the size of the Army has been reduced to 2,500,000 men, the Army expects to release 30,000 doctors of medicine. This will represent a 70 per cent cut in the peak medical corps strength on V-E Day.

Under the new system for discharges, any Army doctor (except about 200 scarce specialists) may now be released if he (a) was in the service before Pearl Harbor; (b) is forty-eight or older; or (c) has eighty or more discharge points. Any of the three qualifications is sufficient for discharge.

Heretofore the discharge age was fifty years and the point score was 100.

MSMS Radio Hours, WJR, Detroit
Fridays—6:30 p.m., E.S.T.

INSTITUTE FOR OCCUPATIONAL HEALTH RESEARCH

As the first step in making Detroit a world center for teaching and research in the field of industrial health, articles of incorporation for a new non-profit corporation to be known as the Institute for Occupational Health Research will be filed in Lansing in October.

The Institute will be staffed with specialists in the medical and engineering phases of employee health, and will maintain ample research laboratories which will be

at the service of industry in Wayne County and elsewhere.

Subject to approval by the Board of Education, the Institute will be affiliated with and housed with Wayne University's new School of Occupational Health, whose program is entirely financed by the Medical Science Center. Dr. Raymond Hussey, dean of the School, will serve as Director of the Institute.

The sum of \$750,000 is now being raised by the Medical Science Center to finance the joint program of the School and the Institute for the first five years, Mr. Anderson said. He added that a substantial part of the \$750,000 has already been pledged. Manufacturing and business firms of Wayne County are being asked to subscribe this money, which will be administered by the Institute's own Board of Trustees composed of leaders in industry.

The affiliated School and Institute will be both a service unit for industry and an educational institution. The School will educate, on a postgraduate level, graduate doctors and engineers who wish to specialize in the field of occupational health. In addition, courses will be available to industrial physicians and hygiene engineers. Later the School will arrange special courses for the training of technicians.

For graduate doctors and engineers the School will offer a two-year course, of which half the time will be spent in plants. Upon graduation, doctors will receive the degree of Doctor of Industrial Health, and engineers the degree of Doctor of Science in Industrial Health.

The Institute's staff and laboratory will be available to industry at reasonable cost. In general, it will concern itself with the health of all persons engaged in business and industrial occupations. It will accept a limited number of industrial concerns as clients, and supervise their employee health programs, though it will at no time engage in the practice of clinical medicine. It will, on request, study the biological effects, harmful or otherwise, of manufactured products and manufacturing processes on workers and consumers. It will conduct researches in the field of occupational health, and publish and disseminate information in this field.

The School of Occupational Health, meanwhile, will utilize the Institute's laboratory, experiments and employee health maintenance program as part of its instruction activities, much as a hospital is used for the teaching of medical students.

It is anticipated that the School will be ready to accept enrollments by the Fall of 1946. The Institute will be in operation before that time. For the time being, both School and Institute will be situated in one of the large houses recently condemned for the use of Wayne University. Eventually a commodious building will be provided in the Medical Science Center.

Dr. Raymond Hussey, who will be dean of the School and Director of the Institute, is now canvassing the country for outstanding medical and engineering personnel in the field of industrial health. These will comprise the faculty of the School and staff of the Institute.

"No institution of the kind we are about to establish exists anywhere in the world," Dr. Hussey said. "We shall emphasize the humanistic approach to the problem,

(Continued on Page 1012)



This, too, will be written in history



Among the many brilliant originations, the inspired improvisations, of the Medical Corps in World War II was the use of the "ambulance on wings."

When the photograph above was taken, the casualties lined up had *just been wounded!* Already they had been given emergency medical aid, and in a matter of *minutes* were on their way to a base hospital with complete facilities far away from the combat zone . . . Thanks to such immediate surgical care, quick hospitaliza-

tion, and all the companion advancements of wartime medical science, 97 out of every 100 such casualties *lived!*

Thanks should be proffered most generously to the incredible diligence of those "soldiers in white" who created and tirelessly practiced these techniques—the medical men in the service whose rest all too often was no more than a moment and a cigarette. Incidentally, that cigarette was very likely a Camel, an especial favorite of all fighting men.

J. Reynolds Tobacco Company, Winston-Salem, North Carolina



Camels

COSTLIER
TOBACCOS.



INSTITUTE FOR OCCUPATIONAL HEALTH RESEARCH*(Continued from Page 1010)*

and the concept of positive health, which recognizes the study of health for its own sake, rather than regarding health as the absence of disease. We shall of course cooperate with existing public health organizations and agencies.

"It is to the mutual advantage of both labor and management that all employes—from the shop worker to the top executive—be provided with safe and healthful working conditions. Further, it is coming to be realized that the problem of employe health extends around the clock. The employe must be thought of as a human being with a budget to balance, and a family to be kept happy and comfortable.

"We will be prepared to go into a plant, survey it, and provide full employe health supervision of both an engineering and a medical nature. We shall make recommendations on such subjects as ventilation, clothing, protective devices, and all others relating to employe health. The actual practice of medicine, of course, will be left to the medical profession. We shall also be training industrial physicians, and engineers who wish to specialize in such employe health matters as illumination, noise, ventilation, temperature and humidity, plant sanitation, hygiene and safety, et cetera.

"While a few very large industrial organizations have their own well-developed laboratories and health programs, small industry desperately needs the kind of agency we propose to build. The demand for people so trained is urgent and very heavy.

"In the variety of courses and training programs which the School of Occupational Health will offer, the School will draw upon the resources of the other schools and departments of the University that are interested in training programs for business and industry."

Among instructional departments which Dr. Hussey proposes to establish in the new School of Occupational Health are the following:

Preventive Medicine: Bases for health; health assessment through physical and mental examinations, study of fitness and capacity, selective placement; health education; personal and occupational hygiene; nutrition; epidemiology; applied physiology.

Preventive Engineering: Plant surveys, equipment design, performance tests; operation control in such phases as mechanical systems, ventilation, and air purification; plant housekeeping; industrial chemistry and the proper control of raw materials; plant and personal hygiene, plant and personal safety; plant sanitation.

Occupational health economics: The gathering and interpreting of reliable and significant statistics; compensation and other insurance.

Administration: Organization of health service; physician-employe relations; personnel department, management and labor relations; the family physician-employe relations; health nursing; placement examinations and job assignment; job analysis principles, plant health inventory.

Physical medicine: Rehabilitation; health considerations in vocational guidance; job placement and adjustment.

Clinical industrial medicine: Internal medicine and surgery and their specialties, with particular reference to occupational accidents and diseases. This part of the program will be developed co-jointly with the faculty of the College of Medicine.

MSMS Radio Hours, WJR, Detroit
Fridays—6:30 p.m., E.S.T.

THE CANCER SITUATION

The mortality from cancer, particularly among women, is beginning to come under control. This is indicated by the experience among the many millions of Industrial policyholders of the Metropolitan Life Insurance Company and is confirmed by other sources. In the past decade, for example, the age-adjusted death rate from cancer among insured white females dropped 11 per cent at ages 1 to 74 years; virtually every important age group shared in the improvement. The current mortality from the disease among women in the broad age range 35 to 64, is the lowest in a third of a century, having dropped by one fifth during that period.

Among white male policyholders, too, a favorable indication is noted. The distinctly upward trend which had been manifested for many years has been stemmed. In fact, during the past decade, at no age beyond 25 years has the cancer death rate among these men shown any increase, and at some age periods the mortality has tended downward recently.

That the organized movement to control cancer is bearing fruit is evident from the fact that people, and more especially women, are seeking diagnosis and treatment earlier in the course of the disease, when the chances of cure are best. For example, among the patients at the cancer clinics in Massachusetts, the average delay between first symptoms and visit to physician was reduced from somewhat more than six months in the period 1927 to 1935, to 3.3 months in 1943.

FUTURE MEDICAL PRACTICE

Local medical societies cannot create opportunities even when they would like to have more doctors start practice in their areas. It is farmers and businessmen serving rural sections who must develop the opportunities which will attract doctors—as for example, by establishing or improving a local hospital, by assuring income through a prepayment plan, or by a tie-up with an industry, a health department or a local co-operative association.—MICHAEL M. DAVIS, "More Things than One," *Survey Graphic*, 34:42, August, 1945.

INCOME TAX EXCLUSION FOR SERVICEMEN

The first \$1,500 of service pay is excluded in figuring income of service men and women subject to tax. This would be continued after veterans are separated from service, if Senator George wins his point in Congress. Even if this is not voted, some preferential tax treatment will be accorded discharged veterans, applying to the year 1946.

For prolonged Bacteriostasis in Nasal and Sinus Infections

... When Paredrine-Sulfathiazole Suspension is instilled into the nose on retiring, the Microform (microcrystalline) sulfathiazole can often be observed on *infected* mucosa the next morning—conclusive evidence that bacteriostasis has persisted all night long.

The fundamental reason for the striking success of Paredrine-Sulfathiazole Suspension is the fact that it is not a solution, but a suspension of microcrystals of free sulfathiazole. Unlike solutions of sodium sulfathiazole, the Suspension does not quickly wash away. It remains on those areas where ciliary action is impaired by infection—and thus provides prolonged bacteriostasis precisely where it is needed most.

In addition to this outstanding advantage, Paredrine-Sulfathiazole Suspension—whose pH range is slightly acid, 5.5 to 6.5—does not irritate or sting, and it does not produce such central nervous side effects as insomnia, restlessness and nervousness.

SMITH, KLINE & FRENCH LABORATORIES
PHILADELPHIA, PA.

It's The Law, Doctor!

Juris ignorantia est, cum jus nostrum ignoramus—Old Maxim

NOTES ON COURT DECISIONS, STATUTES AND OTHER AUTHORITIES

J. JOSEPH HERBERT, LL.B., General Counsel MSMS
Manistique, Michigan

THE NEBRASKA OSTEOPATHY CASE (Concluded)

State vs. Wagner

297 N.W. 906

The court next turned its attention to the question of the right of an osteopath to practice obstetrics. As far as specific statutory authority was concerned, the osteopath was in no better position to practice obstetrics than operative surgery. However, the court again examined statutory history in order to determine whether the legislature had modified the accepted definition or extended the limits of osteopathic practice. The acts of 1901, 1905, 1909, and 1919 all required that "an osteopathic physician" report births the same as doctors of medicine. In 1907 the old law was entirely rewritten, and the new act employed the expression "physician in attendance" without specifically using the term "osteopathic physician" or making specific reference to any particular school of physicians.

The court said, "Of course, the present statute does not specifically require an osteopath to report births, but the former statute did, and we do not think the enactment of the present law evidences any intent to limit the practice of the osteopath in the field of obstetrics from that which had theretofore existed. It is a fundamental principle of statutory construction that the legislature must be presumed to have had in mind all previous legislation upon the subject, so that in the construction of a statute we must consider the pre-existing law and any other acts relating to the same subject. We therefore reach the conclusion that the legislature has recognized obstetrics as a branch of osteopathy, a conclusion which the court is obliged to follow until the legislature by specific action evidences a contrary view. We are therefore of the opinion, after an examination of the legislative history of the laws pertaining to osteopathy and their relation to obstetrics and regulatory requirements as to reporting childbirths, that the legislature has authorized a licensed practitioner of osteopathy to engage in the practice of obstetrics, and that the use of the word 'physician' in section 71-2404, Comp. St. 1929, was intended to include regularly licensed osteopathic physicians."

Lastly, the court disposed of the question as to whether an osteopath is authorized to use anesthetics.

The 1919 Act provided in part as follows: "Nothing

in this act shall be construed so as to authorize the administration, by an osteopath of drugs excepting anesthetics, antiseptics, antidotes for poisons and narcotics for temporary relief of suffering." This clearly gave osteopaths the right to use anesthetics. However, the new 1927 act contained no analogous language. The omission in the current act was interpreted by the court as follows: "We do not think the passage of the 1927 act manifests any legislative intent to deprive the defendant of his previously acquired privilege to use anesthetics, antiseptics, antidotes for poisons and narcotics for temporary relief of suffering. We are inclined to the view that when a legislative act grants a privilege, as was done in the case at bar, a subsequent enactment will not be construed to deprive a beneficiary of the privilege conferred unless a legislative intent to so do is clearly apparent from the legislation itself. For these reasons, we hold that the defendant under the statutes as they now exist, is entitled to use anesthetics by virtue of his license to practice osteopathy."

An analysis of the Nebraska Case makes it abundantly clear that its rationale rests not only on the accepted definition of "osteopathy," but more particularly on the extent to which the definition has been modified in the course of statutory history and by current statutes of that state. Caution must be, therefore, exercised in applying the Nebraska decision to situations in states wherein current statutes and former laws may materially vary from those in Nebraska.

BILLS TO PROMOTE SCIENTIFIC RESEARCH

Three bills have been introduced to promote the progress of science and the useful arts, to secure the national defense and to advance the national health, prosperity and welfare, S. 1285, introduced by Senator Magnuson, Washington, H. R. 3852, introduced by Representative Mills, Arkansas, and H. R. 3860, introduced by Representative Randolph, West Virginia. These bills undertake to effectuate the recommendations of the report submitted recently to President Truman by Dr. Vannevar Bush and other scientists.—*JAMA*, July 28, 1945.



why
ESTINYL tablets
in the menopause

BECAUSE symptoms are controlled within a few days with only one 0.05 mg. ESTINYL (ethinyl estradiol) Tablet daily or every other day.

BECAUSE ESTINYL is well tolerated — Nausea and vomiting are uncommon, and patients experience a sense of well-being that helps smooth this transitional period.

BECAUSE ESTINYL is an economical preparation available to patients who require a potent estrogen derived from natural sources.

TRADE-MARK ESTINYL—REG. U. S. PAT. OFF.



Schering CORPORATION • BLOOMFIELD, NEW JERSEY

Editorial Opinion

"MAY THE LITTLE MEN KEEP THEIR PIPES FILLED"

The trustees of Michigan Medical Service, the Wayne County Advisory Board thereof, and the State Society Council met in a two-day joint conference at Mackinac Island the month of July, the traditional vacation month.

We would like to be able to report that our confreres forgathered at Michigan's garden spot for the sole purpose of indulging in whoopee. But no, if we did we would be indulging in gross and willful fabrication. For them it was just a continuation of the work they've been doing for several years, week in and week out. Time taken from days just as busy as yours and ours without material remuneration and all too often the only reward for their efforts is the criticism of their brethren. We hope the work at hand with added play q.s., made a relaxing mixture. We extend to them and their kind—the work horses of the profession—our thanks and appreciation for the work they do for us "for free," and when they have reached the valhalla where all good departed doctors go "May the Little Men Keep Their Pipes Filled."—FRANK A. WEISER, M.D., Associate Editor, *Detroit Medical News*.

EDUCATIONAL POLICY FOR MEDICINE AND OTHER SCIENCES

The mobilization of the manpower of the country has been a stupendous task. The results of the all-out war effort have so far been cause for some satisfaction and self-congratulation. There has been some criticism, however, that some of the legal limitations of the Manpower Commission have been shortsighted. It is stated that England succeeded in minimizing interruption in the training of the young men who will be her scientific teachers and leaders in the next generation. In Russia, students of ability in science were not put in the armed forces. In our country there has been an all-out policy counting on a short war, and while thousands of young scientists have been delegated to war work, no provision has been made for the continuation of peacetime scientific research.

In the medical field, we have remonstrated

against the failure to exempt from military service the few thousand young men who were contemplating studying medicine and who would be needed to keep the medical schools filled. Since July 1, 1944, only young women and draftees classified as 4F have been allowed to take up pre-medical studies. The medical schools, as a result, will suffer from a lack of students, and in a few years the hospitals will lack sufficient interns so essential to hospital care. There is good reason to believe that there will also be a dearth of physicians to meet postwar needs. Similarly, the scientific schools are suffering from reduced classes, and science will suffer from the termination of postgraduate scientific study. After the war and after these young scientists return from war work or service, there is danger that new family responsibilities and lack of funds may prevent them from resuming their studies for doctorate degrees. Their efforts in war work, as a rule, will be of little value in the peace economy.—*Minnesota Medicine*, July, 1945.

RETURN OF MEDICAL OFFICERS

On another page we are reproducing a statement from the Michigan State Medical Society regarding the release of unneeded medical officers now in military service. This statement is official from the Michigan State Medical Society, signed by the officers of the society and members of the council.

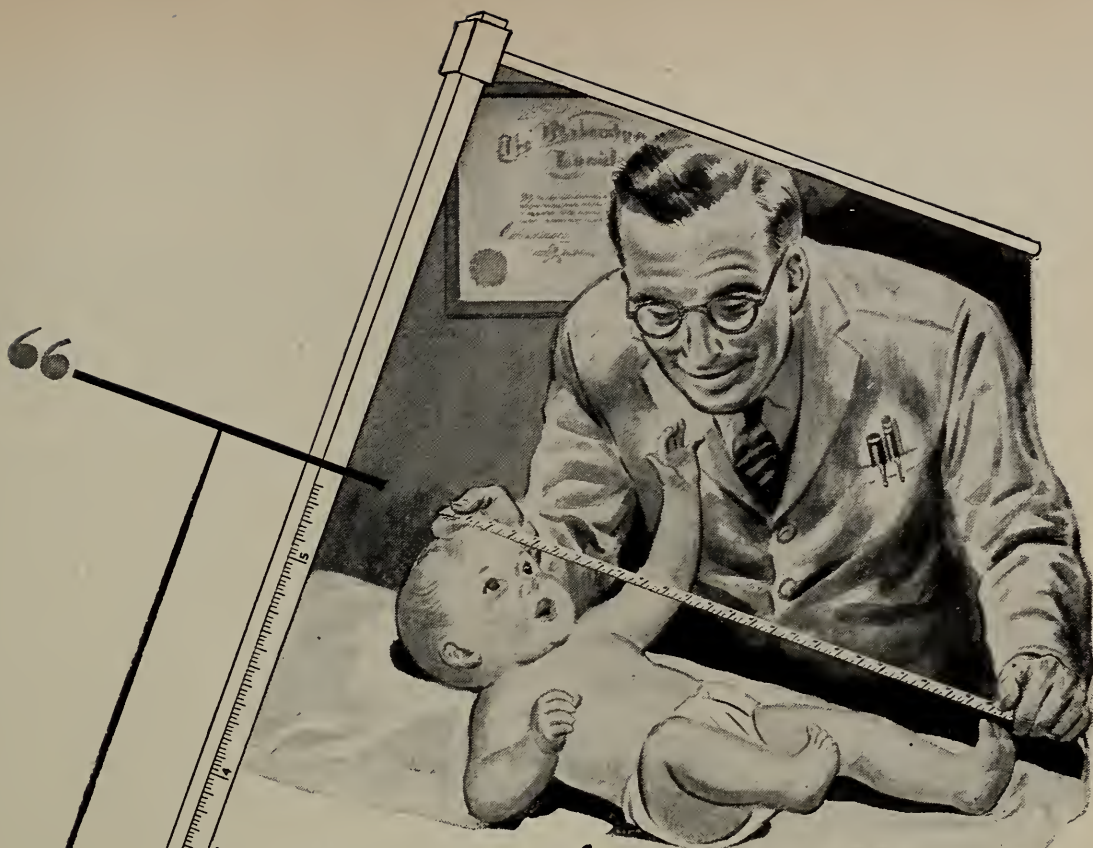
The condition which they describe concerns the welfare of all the people of the United States.

While the Tennessee State Medical Association has not made a similar official statement, we are sure that every member of the profession will heartily approve of the action taken by the Michigan Society.

We have talked to several members of the Medical Corps and it is their opinion that the "medical pool" is entirely out of proportion to the needs of the Army and that the general public is being deprived of badly needed medical attention. The question is also being investigated by a congressional committee.

It is suggested that those of our readers who

(Continued on Page 1020)



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RETURN OF MEDICAL OFFICERS

(Continued from Page 1018)

agree with the Michigan letter express their opinion to their congressmen in support of this measure.—*Journal Tennessee State Medical Society*, August, 1945.

LETTER TO SENATOR WAGNER

This letter is published through the request of the President, the Editorial Board and several members.

June 25, 1945

Senator Robert F. Wagner,
U. S. Senate,
Washington, D. C.

Dear Senator Wagner:

As a member of the Editorial Board of the *Journal* of the Oklahoma State Medical Association, may I acknowledge the receipt of your letter and the copy of your speech before the Senate. I feel that you should not be surprised when I tell you that we have no space in the *JOURNAL* for this material. Your proposals with reference to medical legislation are well known to the doctors of the State because much space in the *Journal* has been occupied with informative articles warning the doctors and the people against regimented medicine in any form. Since your Bill has been reintroduced, this policy shall be continued.

Now, speaking as an humble citizen and a member of the medical profession, may I say that I could be more patient with you and your program if I did not feel sure that you are at least partially aware of what you are trying to do to a great free enterprise which has given to the American people the best medical service ever vouchsafed to any comparable nation.

Medicine has reached its present high mark through an evolutionary process following the path which nature walks. Any change which causes a deviation from this path is dangerous to the welfare of our nation. Washington bureaucrats are now knee-deep in trouble because, contrary to nature's way, they have plowed up, turned under, burned and killed the products of the soil and, without sufficient knowledge of fundamentals, they have monkeyed with supply and demand and paid people not to plant, or unwisely to plant less than they, as farmers, believed they should. It is my understanding that you are having a little trouble with your existing so-called social security. If you had struggled through eight years (the minimum for doctors) of formal education in government and statesmanship before you entered politics, I might feel more secure about your part in law-making, but even then I would question your ability to pass judgment on the merits of medical service and to provide ways and means for its application and distribution.

Bismarck instituted social security including compulsory health insurance in Germany with the avowed purpose of placing the common people under obligation to the Government. A bit of political expediency which, in addition to other evil consequences ultimately snuffed the rising flame of medical science in Germany. Who can say how much the program had to do with the mass psychology which prepared the way for Hitler and his followers. Friedrich Schiller, who laid down the principles of democracy and set forth the tenets for which we fight today, would turn over in his grave if he knew what you and your co-workers are trying to do to a free people. In this connection, it is significant that Schiller became an exile from his own Wurttemberg

rather than practice medicine under the regimentation of Duke Charles. Under German social security the quality of medicine declined and the costs mounted. No Heines, Goethes or Schillers appeared to stabilize a waning social order. Schiller had the courage to walk out on his imperious Duke, Goethe as Minister-in-charge at Weimer, under the roar of Napoleon's cannon at nearby Jena, bravely waited to face the victorious Emperor. The Grand Duke and his court had fled, but Goethe was not afraid. Heine had the courage to place his finger on the obstacles which doctors were meeting in their attempt to advance the cause of public health throughout the civilized world, namely, business interests and tenement owners often operating under political protection.

When the end came to Germany, courage was supplanted by flight and self-administered poison. The latter often retained in the mouth, where at the opportune moment, chattering teeth might nip the vial and release the lethal dose. No Nipponese faith inspires this cowardly act. Rather, it represents the mark of stark degeneracy under a dissolute and wrecked government. If you cherish the approval of posterity, you should reconsider your plans for medical service and promptly retrieve your proposed legislation. If your Bill should be enacted into law, ultimately the people will be pinched by the yoke and they will blame the perpetrator. If the people and the doctors of your own state should choose to follow your proposals, I would have nothing to say. But I am wondering if you realize the United States reaches from ocean to ocean and that the respective states sprawling across the continent present variable and often distinct social, economic, political and even medical problems. From a medical viewpoint, after public health does its job, the solution of these problems belongs to these respective states. Speaking for Oklahoma, we will come up to the draft board as physically fit as your New Yorkers; we will be more typically American; we will last as long in battle and be a little quicker on the trigger. For twenty years I have visited New York two to three times annually. How many times have you crossed the Mississippi to see us? Do you know what we need? We love you and we enjoy fighting for you and we expect to continue putting food on your tables, but please leave us freedom in these essential pursuits. Here's hoping you will have Oklahoma turkeys and Kansas City steaks for Thanksgiving and Christmas.

Now that we do definitely disagree on this controversial problem, why not set up the credentials for our individual opinions? I should not venture to be so personal if the issue were not so ponderous. The following I have taken from *Who's Who in America*, which no doubt had your approval.

"Wagner, Robert Ferdinand: B.S. Degree from the College City of New York, 1898; LL.B., New York Law School, 1900; widower; one son, Robert F., Jr. Practiced at New York City; member New York assembly, 1905-08; Senate, 1908-18; Chm., New York State Factory Investigating Commission, 1911; Lt. Gov. of New York, 1914; Justice, Supreme Court of New York, 1st District, 1919-26; assigned to Appellate Division, 1st Department, 1924 (resigned); member U. S. Senate since 1927; Chairman, Senate Committee on Banking and Currency. Democratic leader, New York Constitutional Convention, 1938. Introduced National Industrial Recovery Act, Social Security Act, National Labor Relations Act, Railway Pension Law, U. S. Housing Act of 1937, and other social and economical legislation in Senate."

I am a native of Kentucky and I grew up in a small town. Eight years of my life were spent in preparation for the practice of medicine, three of these school years on borrowed money. Compared with the present federal subsidies for medical students, borrowing was good fertilizer for the growth of character. I am glad that I

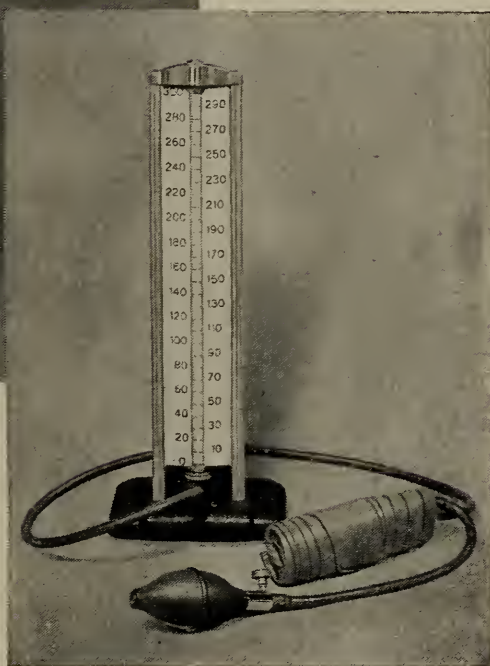
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LETTER TO SENATOR WAGNER

(Continued from Page 1020)

borrowed from Uncle Bob instead of begging from Uncle Sam. In a middle state, east of the Mississippi, I was temporarily a doctor on horse back 25 miles from a railroad. For six years I was a horse and buggy doctor on the plains, replacing my intern service by practice in dugouts, sod houses and prairie shacks. I have been in general practice in a modern small city and later in highly specialized practice with a private sanatorium. One year of medical studies in Europe; twenty years teaching medicine in the University of Oklahoma; three years as Dean of the same school. During my Deanship I was Superintendent of the University Hospital and the Crippled Children's Hospital, both having active out-patient departments serving the whole state.

I have been President of the local Tuberculosis Society and head of a free tuberculosis dispensary for 27 years and a member of the National Tuberculosis Association Board for a corresponding period of time. I have been an humble student of the history of medicine during my professional career and have tried to correlate and integrate the various phases of medical progress during the past 2,500 years.

Through these various interests and intimate contacts with doctors, medical students and patients of all classes, I have a feeling that I may know something about what the American people want and what they need in the way of medical service and what a radical change may do to the high purposes which now dominate the profession. Though this may be difficult for you to understand, I can truthfully say that with few exceptions, doctors are interested in the welfare of the people and not in their own promotion.

Please leave my medicine on this tripod—the patient, doctor, and God. The patient and the doctor usually find their relationship mutually helpful. When they fail in this they are free to make changes or adjustments. God seems to be interested in both and exacts no accounting except reasonable skill and the exercise of conscience, and fortunately he presents no interminable, incomprehensible blanks to be filled out in triplicate.

This lengthy discussion has been long in my system, but I could never presume to trouble you with it until your recent communication provoked this response. Without malice toward you, I am opposed to your program because I am in favor of charity toward all. In closing, may I urge you to study the history of medicine in the United States and try to realize that you and I would not be indulging in this controversy if medicine in the United States had not kept abreast of scientific and mechanistic development in other fields. Our old age problem is pyramiding because American medicine has been good enough to double our longevity in the short period of our national existence. Today if it were not for preventive medicine and sanitary engineering (also medical), the vultures would be roosting on the dome of the Capitol and defiling the most beautiful city in the world with filthy excrement resulting from the reconverted carrion picked from the bones of congressmen, bureaucrats and government employes, who if they are not careful may do to us what Bismarck did to Germany and swing the medical pendulum back for a long and annulling period of decline.

Medical science can never click with the clock; medical progress can never successfully stem the obstacles arising through directives and senseless paper work—even the willing spirit may grow weak under the domination of flesh which is not a part of its own carnal habitat.

Respectfully and humbly submitted for your consideration.

Sincerely,

LEWIS J. MOORMAN, M.D., Editor

Journal of the Oklahoma State Medical Association
LJM/jft

PHYSICIAN SUPPLY INADEQUATE

The Educational Number of the *Journal of the American Medical Association*, September 1, 1945, says:

Even after Uncle Sam has completed his job of demobilization, the United States will need about 30,000 more physicians than before the war. Victor Johnson, Ph.D., M.D., Secretary of the Council on Medical Education and Hospitals of the American Medical Association, said that during the past year there have been virtually no able-bodied male students in medical training.

"Even after demobilization is complete, we shall probably need about 30,000 more physicians than before the war, primarily because of the requirements of the Veterans Administration (about 15,000 physicians) but also because of the needs of the peacetime Navy (about 5,000) and the Army plus possibly a compulsory universal military training program (about 10,000):

"This estimate disregards extra physicians required to provide replacements for casualties among medical officers, medical assistance to liberated countries and the more complete and extensive medical care demanded in this country.

"Even if admissions, enrollments and graduations from our medical schools should continue at the present levels, only about half of this need would be met, since 40,000 students enrolling would receive the M.D. degree in the period 1942 to 1948 and 24,000 physicians will have died during that time. Thus under the most favorable conditions only about 16,000 additional physicians will be available after the war to do the work of 30,000.

"From now until at least 1947, medical school freshmen must be women, or men who were physically disqualified, under or over the draft ages, or veterans. Because people in these categories are limited in numbers, those admitted to our medical schools in the next year or two will be appreciably reduced in numbers or in quality.

"During the three years, to June 30, 1945, there have been 20,662 graduates in the United States. By comparison there were 15,535 graduates in the three immediately preceding war years to June 30, 1942. This represents the graduation of an extra 5,127 students in the past three years. This contribution of medical schools to the successful prosecution of the war is immeasurable. . . ."

However, "during the past three years there has been a fairly general agreement that the accelerated program . . . has been educationally undesirable."

"During the 1944-45 session, there were 129 part-time or special students and 140 graduate students enrolled in some of the medical courses in 40 medical and basic science schools in this country and Canada. These numbers represent still further decreases below the figures of a year ago. In 1940-41 there were 1,167 graduate students in our medical schools. Last year's 140 is only 12 per cent of this number. The Selective Service System and the Army and the Navy have insured a deficiency in medical students, in quantity or quality, in the next few months or years. They have also provided for an even

(Continued on Page 1109)



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Political Medicine

MEDICAL CARE FOR ALL

Dr. Miles Atkinson of the "Physicians' Forum" writes:

We (Physicians' Forum) feel very strongly that such a system of national health insurance should be compulsory rather than voluntary. Voluntary schemes of health insurance have been with us for a long time. In fact, there are more than 200 such plans in effect now, enrolling 21,000,000 of the population, and new ones are springing up all over the country, raised as last-minute dikes by some frightened doctors and others against the encroaching tide of public action. *The main objection to them is the very fact that they are voluntary.*

* * *

The main argument for compulsory health insurance is that nearly all existing voluntary systems give only limited service. The Blue Cross Hospital plans have been quite successful in reaching many people in many cities, but they only pay your hospital bill, not your doctor bill. In twelve years they have reached only 12 per cent of the population. The voluntary plans generally accept for membership only those entering in a group. *This usually excludes wives and children of workers.*

* * *

This sort of insurance puts the emphasis in the wrong place. It treats ills after they have occurred, rather than trying to prevent them before. These cash indemnity plans are favored by the American Medical Association, however, because they preserve an illusion of the traditional method and because payment comes not from the state but from a private company, a large proportion of whose directors are often doctors.

"We progressive doctors believe, along with organized labor, that a bill of the nature of the Wagner-Murray-Dingell Bill should be passed as quickly as possible by the Congress. We hope that organized labor will be active in pushing it, and we ourselves will do all we can to make our voices heard.—American Federationist, 52:26, June, 1945.

One would think a man of Dr. Miles Atkinson's admitted attainments would study the facts about some of our Voluntary Medical Care plans before making such statements. Note his main objection is that they are voluntary.—Editor.

MEDICAL SPONSORSHIP OF WAGNER-MURRAY-DINGELL BILL

Senator Wagner attempts to claim the sponsorship of medical organizations of the country for a gigantic hospital construction program provided for in the bill, but the inference is wrong that American Medicine has or will endorse the program. It far exceeds in cost the hospital construction program provided for in the Hill-Burton Bill, which has been endorsed by officials of the American Medical Association.

Senator Wagner, in presenting the bill, also attempted to convey the idea that proper medical consultation was held in connection with its framing, but the only two

organizations with exclusive medical membership named by him, the Physicians' Forum, a small group in New York state, and the Committee of Physicians for the Improvement of Medical Care, the former self-appointed Committee of 400, now constituting perhaps 1,000, certainly are not representative of medical thought and opinion in the United States.

The Wagner-Murray-Dingell Bill, 1945 Version *Texas State Journal of Medicine*, 41:53, June, 1945.

MEDICAL PLANS

Whether we like it or not, we, as practitioners of medicine, are living in a world which is changing very rapidly. My belief is that unless we assume a leadership in adapting medical practice to the social, economic, and scientific progress that has been, and is being, made in our lifetime, the consequences will be tragic. It has seemed to me that much of our reaction to any discussion of so-called "socialized medicine" has been essentially demagogic. In my opinion, the practice of medicine has always been and is now socialized by its very precepts. What I, and I believe, you, are against is governmental medicine with its attendant bureaucracy. I believe that real leadership in medicine can evolve a plan which will provide adequate medical care for our people. What I fear is that we will not develop this leadership. The Murray-Wagner-Dingell Bill threatens to centralize administration of medical care and bring it under federal government control. I do not believe it will become law in its present form or that its proponents even hoped it would. But I do believe that a bill cut from the same general pattern will eventually pass, unless we, as medical men, evolve a plan which will make governmental medicine unnecessary.—KYLE C. COPENHAVER, M.D., Presidential Address—*Journal Tennessee State Medical Association*, May, 1945.

RHODE ISLAND STATE FUND FACES HUGE DEFICIT

Rhode Island's cash sickness insurance system—the only one of its kind in the nation—was reported as of May 15, as facing insolvency in 1947 if the present pattern of rising disbursements and declining contributions continues and no action is taken to tighten up on eligibility benefits. The system was reported as apparently headed for a \$1,000,000 deficit this year, nearly twice the 1944 deficit of \$587,237, as its reserve fund dwindled from a peak of \$3,815,686 at the end of February, 1944, to \$2,720,207, April 30. Benefit payments during the first week in May were the highest in eight months, while April receipts were 27% below the fund's income in April, 1944.

Unemployment Compensation Board figures show that the pattern of rising payments with the start of a new benefit year on April 1, when many persons who had exhausted their benefits during the previous year start col-

(Continued on Page 1026)

"...inhalation
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dramatic relief
through the
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effect on the
mucosa,
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Salinger, S.: Arch. Otolaryng. 4:40, 324,
noting Box, H.E.H.: M. J. Australia 2:126.

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RHODE ISLAND STATE FUND FACES HUGE DEFICIT

(Continued from Page 1024)

lecting again, was beginning to repeat itself again, but that this year the jump was even more pronounced than a year ago.—*Eastern Underwriter*, 46:29, (June 8) 1945.

STATE OF THE NATION—PRESIDENT TRUMAN

Aid to Hospitals

"The federal government must continue to recognize its obligation to maintain and improve the health of the nation by providing federal grants where necessary for the construction of hospital and health centers."

National Health Program

"I shall shortly recommend a national health program to provide adequate medical care for all Americans and to protect them from financial loss and hardships resulting from illness and accident. I shall also communicate with the congress with respect to expending our social security system, and improving our program of education for our citizens."

The above two quotations are from President Truman's message to Congress on September 6, 1945, upon the State of the Nation. We are looking forward to the details, and hope when it comes the President will have consulted with actual representatives of the Medical and Hospital services.

He further states:

"Programs of internal improvements of a public character—federal, state, and local—must preserve competitive bidding, guarantee collective bargaining, and good wages for labor, utilize the skills of our returned veterans to the fullest extent, and effectively prevent discrimination because of race, creed, or color."

In view of these remarks, we trust that he will insist upon the same privileges for the professions most interested in health service.—EDITOR

* * *

"You can't find many doctors here who don't believe in the superior merits of competitive private practice to socialized medicine. The great medical work being done in this war is being done by men who qualified first in private practice, just as the war production under governmental control is done by men and plants developed through generations of private enterprise."—JOHN TEMPLE GRAVES, *The Birmingham Age-Herald*.

* * *

Senator Wagner calls attention to the number of organizations which have been consulted in the preparation of S. 1050. But he does not mention the American Medical Association or the National Physicians Committee.

"Indeed, the Wagner-Murray-Dingell Bill, in the successive editions, has done more to mobilize opposition to the extension of social security than any opponent social security has encountered. It has forced the foes of social security to organize and to band together in a solid phalanx which, at the moment, is almost impregnable. It is to be hoped that it has also made the proponents of broader social security aware of the fight ahead of them. . . .

"When the existing system is held up to the light of objective scrutiny and its improvement considered, the Wagner-Murray-Dingell Bill offers an architect's drawings of a remodeled structure. *Pessimistically, I doubt*

whether we shall be willing to take any effective steps toward those goals until the unemployment figures mount steeply again. In the meantime the discussion and study of plans which must precede any real advance in a democracy are stimulated by the Wagner-Murray-Dingell Bill of 1945."—JOHN J. CORSON, *Survey Graphic*, June, 1945. (Formerly director of the Bureau of Old Age and Survivors Insurance, U.S.E.S.)

REPORT OF THE MSMS DRAFTING PANEL

The editor of the *Oakland County Medical Bulletin* comments as follows on the report of the Michigan State Medical Society Drafting Panel:

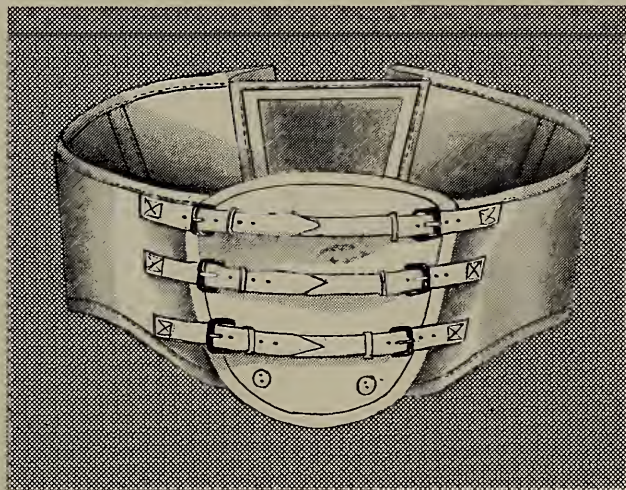
"The report . . . shows what we here in Michigan propose as an alternative to Federal Health Insurance. If the Federal government will agree to pay the premium on a Michigan Medical and Hospital Service policy for all those on Welfare or others commonly known as government wards as well as disabled ex-servicemen a program will ensue that has all of the advantages and few if any of the disadvantages of legislation already proposed in Washington and some of the State legislatures. We congratulate this Drafting Panel for its constructive proposal. Now try and get Morris Fishbein to approve such a plan on a nationwide level and American Medicine will have answered the challenge handed it by all of the social planners during the past fifteen years. Michigan Medical Service can be broadened to include medical care in the future and then we will have provided medical service for all citizens regardless of their social status in a truly American manner."

The report may be summarized as follows: "A medical-care program to be successful must be a program . . . which can offer *good* medical care to *all* the people. It should be a program which must be built upon a *group co-operative* effort on the part of medical men and that will fit in with the aspirations of the medical public; in short, a picture of various medical-care producers' co-operatives and of medical consumers with the accent on free-will, enterprise and conscience. It is our thought that voluntary medical prepayment plans, if allowed to flourish, can well cover the large majority of our total population. The remaining of those in total or partial need of medical necessities (and quite likely in need of other necessities), can be very well taken care of by consumer subsidies. It is our belief that the Federal Government in this medical instance can do best by the encouragement of state-wide co-operatives through either loans or technical aid and reserve their outright cash grants for the purchase of medical care certificates for those unable to purchase their own prepayment security. . . . We further endorse the . . . fee for service basis of payment to the doctor so as to preserve the benefits of competition and maintain the quality of service. . . . Medical-care co-operatives (producers' type co-operatives) can and should be set up in every state."—*Oakland County Medical Society Bulletin*, June, 1945.

(Quoted to refresh our minds as to the genesis of a program approved by Morris Fishbein and promulgated by the Council on Medical Service and Public Relations in the recently announced Fourteen Points.—EDITOR, *Oakland County Medical Society Bulletin*.)

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War Medicine

ARMY RELEASING 30,000 DOCTORS

The army will release at least 30,000 doctors, 10,000 dentists and more than 40,000 nurses by next July 1, the war department announced today.

This will represent, the department said, approximately 70 per cent of the peak strength of the medical corps at V-E Day.

By next July 1, the over-all strength of the army will be cut to 2,500,000.

Under a new discharge system, 13,000 physicians, 25,000 nurses, 3,500 dentists and a "large number" of other medical department officers will be returned to civilian life by January 1. This new system for medical department officers no longer needed by the army involves a combination of lower point scores, age and length of service.

The department said that medical and dental corps officers will be considered surplus and released if they had 80 points September 2, 1945, or are 48 years of age or older, or if they entered the service prior to December 7, 1941. Previously, a medical or dental corps officer needed from 100 to 110 points or had to be 50 years of age or older in order to gain his release.

Nurses will be released if they have 35 points, or are 35 years of age or older, or are married or have dependents under 14 years of age. Nurses previously have been released if they had 65 points or were forty years of age or older.

* * *

This release followed two days after Governor Kelley of Michigan went to Washington requesting the release of surplus Michigan Doctors. He stated that Michigan asked for no doctors needed by the military but that the 2,287 Michigan doctors were a number way over Michigan's quota, they had faithfully served, and there were 88 Michigan communities stripped completely of doctors to supply the armed forces. These doctors are now needed at home, without delay. The civilian populace has been served at great sacrifice by the doctors at home, many of them over age, and recalled from retirement for the emergency. The Governor protested that so far less than one hundred doctors have been released from the services.

PACIFIC MEDICAL CONFERENCE

One of the most important medical meetings of this war was held in the Office of The Surgeon General, Washington, D. C., on July 30, 31, and August 1, and was attended by outstanding experts in surgery, medicine and disease control from all theaters of operation throughout the world.

Major General Norman T. Kirk, The Surgeon General, called the meeting "to pool the knowledge and experience of the men from the fighting fronts in order that the lessons learned thus far in the war can be more thoroughly applied than ever before in the conservation of human life."

In addition to about forty of the country's leading medical experts from the overseas theaters, General Kirk had officers from virtually every division and branch of the Office of The Surgeon General attend the meetings and thoroughly discuss all phases of medical and surgical care, supply, transportation, training, and related subjects.

Such problems as the redeployment of millions of men to the Pacific areas were discussed. It was pointed out that the transfer of such vast numbers of American troops will invariably present health problems, but does not make the job impossible or unnecessarily difficult because of the experience of three and one-half years of facing and successfully fighting and controlling disease hazards of these areas.

More effective means for the treatment and care of both wounded and sick troops near the front was another principal question studied at the meeting. It has been proven in the campaigns to date that such care has paid great dividends in the saving of lives and the alleviation of suffering, and the methods used are to be extended as far forward and as rapidly as is humanly possible.

PLASTIC ARTIFICIAL EYES

Thirty installations, twenty-nine general hospitals and one regional hospital have been designated plastic eye centers for the Army Medical Department. "There is no existing backlog for plastic eyes and it is not contemplated that any more centers will be opened," said Major Trygve Gundersen, MC, Chief Consultant in Ophthalmology to Major General Norman T. Kirk, The Surgeon General.

As of June 30, 1945, approximately 5100 plastic artificial eyes have been made and fitted. In addition, the plastic eye laboratories have made conformers, eye spheres and other appliances for the eye clinics.

Experimental work is still being carried on in the plastic artificial eye program. Technicians are continually endeavoring to improve and give these plastic eyes greater mobility and lessen abrasion.

STREPTOMYCIN BEING STUDIED

A new drug, streptomycin, companion to penicillin as a killer of bacteria, is being studied and undergoing tests by the Army Medical Department to determine its suitability as a germ killer in saving the lives of wounded and sick American soldiers.

The new drug shows possibilities which may prove to be as important to the medical profession as was the discovery of penicillin. Streptomycin is a killer of Gram-negative bacteria, such as tuberculosis, cholera, dysentery, typhoid, tularemia and salmonella food poisoning. Penicillin is a killer of gram-positive bacteria, such as pneumococcus, streptococcus, staphylococcus, gonococcus and syphilis.

Even though the new drug is still in the laboratory

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A Doctor's Life

By Andrew S. Brunk, M.D.

President, Michigan State Medical Society
Detroit, Michigan



MOST DOCTORS of Medicine are made before they are born. Heredity, with the timeless mandate of the Oath of Hippocrates—"I will impart knowledge of the art to my own sons"—accounts for a goodly per cent of our confraternity. A mixture of propinquity and of environment reckons most of the balance. Thus, many times before a child is conceived, circumstances or influences have predestined its life as a practitioner of medicine.

No magic wand could possibly be used to foreordain such a fate. For if ever a child faced a life of never-ceasing labor midst constant grief and pain, it is the boy or girl who is to become a practicing doctor of medicine.

Minimum Essentials of a Doctor of Medicine

First, let us see what educational hurdles must be overcome:

Presented before the House of Delegates of the Michigan State Medical Society, Eightieth Annual Session, Detroit, September 18, 1945.

1. Four years of High School.
2. Four years of College, including the basic sciences of anatomy, physiology, bacteriology, pathology, chemistry, hygiene and public health.
3. Four years in a Class A Medical School.
4. One year's rotating internship in an accredited hospital.
5. One to five years' residency in a specialty hospital.

Our boy or girl by this time is a mature adult. In fact, the young doctor of medicine is twenty-nine to thirty-two years of age, and has devoted practically the first half of his expectant life to study, without remuneration of any kind. He or she has sacrificed—"wasted" is the vernacular—at least ten production years. The new M.D. has enjoyed neither the pleasures of worldly possessions nor the joys of family life. His only capital is knowledge—and that range of understanding is limited to the science of medicine—a small segment indeed of the whole of science which in time is but an atom in the field of knowledge.

But what the doctor knows is important. He has a knowledge of the human body—its normal structures, functions and governing laws; he has a knowledge of most diseases, so is able to diagnose what disease is present in a patient; he has a knowledge of effective remedial agents and the ability to apply the one most needed.

The Art of Medical Practice

Now the young middle-aged doctor of medicine can step out—if in the meantime he has endured successfully the agonies of the basic science board and the state medical board examinations—and assume the most important part of his

career. He is ready for the experience and the art of medical *practice*. For years he has been a slave of institutions; now he becomes the vassal of the people, his patients. He is free to endure long hours, disturbed sleep, worries over patients, to become father-confessor to hundreds, hearing through the day and night the suffering and sorrow of a troubled people. But always being mindful that a cheerful demeanor must be assumed by the doctor to bring encouragement and confidence to his patients.

He leads a strenuous life to dispense needed care to the people. He always has too much work to do, and unless the nation is at boom-tide, his income is astonishingly low when compared to his industry and costly background.

Need for Continuous Study

Meanwhile, what about his education that absorbed the first half of his life? The doctor's study is never done, we are told. And yet the problems of maintaining a large practice and at the same time keeping abreast of the rapidly advancing science of medicine is not easily solved. The need for continuous study by a doctor of medicine is but one of the penalties of his profession. This requires time and money, neither of which is given in generous amounts to the practitioner of the healing arts. He requires a financial surplus to take time off to pursue postgraduate instruction, since no income accrues to him when he absents himself from his practice, even for one day. But he knows what will be his station if he fails to continue his studies, if he doesn't open a reference book, attend his county and state medical society meetings, or attend postgraduate courses. At the end of five years, he is stale, serving medicine which is not up to date; at the end of ten years, he is perpetuating a fraud on his patients; and at the end of twenty years, he has few patients and has made of himself a pariah in Medicine.

Michigan's Outstanding Postgraduate Medical Education Programs

Fortunately, there are very few Doctors of Medicine in any of those classes in Michigan. Thanks to the pioneering efforts of the Michigan State Medical Society, the postgraduate medical education opportunities in this State are outstanding. The intramural work at the Medical Universities is unparalleled. The extramural continu-

ation courses bring postgraduate medicine to the Doctor's front door, to spare his precious time and conserve it for his patients. He obtains excellent postgraduate instruction in his own home town.

The net result is that Michigan people are being better served with better medicine. Their morbidity rates are low—reminding one of the gratifying rates in the military services whose medical departments are manned exclusively by Doctors of Medicine; news reports indicate that more than 90% of all lives are saved in the armed forces—a glowing tribute to medical education, postgraduate training and skill. Similar figures in civilian life astonish even the medical men.

We, in this State, must ever be grateful to the Michigan State Medical Society Committee on Postgraduate Medical Education of which James D. Bruce, M.D., has been Chairman and motivating influence for years. Verily the mountain has been moved to Mohammed by this Committee.

The Michigan Foundation for Medical and Health Education

The work of the Postgraduate Medical Education Committee has required substantial financing over the past fifteen years. With the great and immediate need for increasing the work—to accommodate the returning medical veteran with his acute problems in postgraduate medical education—the cost will be accelerated amazingly. But the show must go on, and be a better performance. This is why the Michigan State Medical Society recently created the "Michigan Foundation for Medical and Health Education." Its purposes are to acquire, provide, use, develop, endow, and finance methods, means and facilities for postgraduate education in Medicine, for education in Medicine, for lay health education, and for research, fellowships and scholarships.

Any high-minded activity, designed to benefit the public, deserves the support of the medical profession. But when that movement benefits the people through the aegis of the medical man alone, then his responsibility to support the work is real and great. The individual Doctor of Medicine—every member of the Michigan State Medical Society—owes something and usually much to the noble profession which has brought him gratifying rewards for oftentimes arduous but ever-stimulat-

ing service. No greater self-satisfaction can be achieved by a physician than by contributing some portion of that reward (no matter how small in dollars it may be) towards the preservation of the profession he loves.

In my sincere effort to recommend the Michigan Foundation for Medical and Health Education to the consideration of our doctors—who personally or through influence with patients and friends, are able financially to help build this monument to Michigan Medicine—Mrs. Brunk and our son Perry, his wife, Lulie, and I desire to make the following offer: we shall contribute the sum of \$1,000.00 to the Michigan Foundation for Medical and Health Education, provided 99 other members of the Michigan State Medical Society contribute a like sum during the next twelve-month period.

This will total \$100,000.00 which, with the present actual and pledged monies in the Michigan Medical Foundation, will represent a sum in excess of \$150,000.00, by September, 1946. The income from the Fund then will begin to offer returns in postgraduate work for all members of the Michigan State Medical Society—including medical officers separated from military service—without further delay.

My offer holds good for 365 days, and I recommend that this matter be referred to the Council and Postgraduate Foundation Committee for favorable action, and that they give consideration to the creation of a group of founders to consist of those who contribute \$1,000.00, or more, before or during the period indicated in this offer, up to September, 1946; and that the Postgraduate Foundation Committee (augmented, if need be) conduct a dignified campaign among the members in behalf of an additional \$100,000.00 in the next year, for the Michigan Foundation for Medical and Health Education.

Our Foundation has created an instant appeal. Only today, in casually mentioning the possibilities of this educational foundation to only a few physicians, I was astonished at the reception it received.

Here, gentlemen, is an important announcement:

The following doctors of medicine, members of the Michigan State Medical Society, already

have pledged to contribute the sum of \$1,000 each to the Foundation during the next year:

1. James D. Bruce, M.D., Ann Arbor, \$1,000
2. Earl I. Carr, M.D., Lansing, \$1,000
3. C. V. Costello, M.D., Holland, \$1,000
4. H. H. Cummings, M.D., Ann Arbor, \$1,000
5. L. J. Hirschman, M.D., Detroit, \$1,000
6. Wm. A. Hyland, M.D., Grand Rapids, \$1,000
7. Joint Committee on Health Education, B. R. Corbus, M.D., Grand Rapids, Chairman, \$1,000
8. Mrs. F. B. Miner, Flint, in memory of the late F. B. Miner, \$1,000
9. Harold L. Morris, M.D., Detroit, \$1,000
10. Lawrence Reynolds, M.D., Detroit, \$1,000
11. J. M. Robb, M.D., Detroit, \$1,000
12. G. B. Saltonstall, M.D., Charlevoix, \$1,000
13. E. R. Witwer, M.D., Detroit, \$1,000

That, together with our pledge, makes a total of \$14,000 already pledged for the Foundation.

One contributor, E. F. Sladek, M.D., of Traverse City, has set aside in his will the sum of \$5,000 for the Foundation. That raises today's pledges to \$19,000.

Undergraduate Education in Medicine

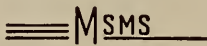
The Michigan Foundation for Medical and Health Education includes more than postgraduate education. It includes undergraduate "education in medicine" in the Purposes. I cannot refrain from urging on you the need for heavy support of the present system of medical education. Let me call it the "voluntary or free" type in contrast to government-directed training. I am disturbed about those students whose training is now being directed by the military. Yes, these doctors will help eventually to bring needed service to the people, but, will many of these young men and women who are subjected to the regime of the State, emerge as proponents of systems foreign to those concepts which have brought medicine in this Country to its Golden Age?

Gentlemen, in the interests of Better Health for the American People, I urge a large endowment in the "Michigan Foundation for Medical and Health Education," so that the proceeds thereof can help preserve the art as well as the science of Medicine on the basis of private enterprise, which has made American Medicine the greatest in the world.

Better Health and Longer Life for the American People

May I prophecy that if this and similar Foundations throughout the United States are properly endowed, if partly through influence, Medicine continues unshackled and free to pursue its research, its improvement of medical practice, and the wide distribution thereof, that we stand on the threshold of an era of unbelievable scientific achievement in the field of Medicine. These Foundations for Medical and Health Education may be the means of extending life and permitting the people to live far more comfortably during the enjoyment of a longer period on this earth.

With the greatest sincerity, I submit the Michigan Foundation for Medical and Health Education to your thoughtful consideration.



Problems Arising from Michigan's New Compensation Law

By Theodore P. Ryan, LL.B.
Lansing, Michigan



WE, in the Department of Labor and Industry, have occasion to hear and read an abundance of medical testimony. I might even break down and admit that this testimony is predominately good testimony although sometimes a doctor forgets that he is the doctor and not the lawyer in the case. In hearing and reading this

Presented at the Third Annual Postgraduate Conference sponsored by the Committee on Industrial Health of the Michigan State Medical Society, in co-operation with the Department of Postgraduate Medical Education of the University of Michigan, Thursday, April 5, 1945, Detroit, Michigan.

testimony, we many times come across the admission or assertion, as the case may be, that medicine is not an exact science. As it is with medicine so also is it with the law. Much of what I shall say will be a matter of legal opinion and as practitioners of an equally inexact science I ask you to bear with me if I do not appear to have all the answers. Our Supreme Court has not yet passed upon the question with which I am going to deal.

Some thirty to thirty-five years ago the problem facing the various states was: Shall we adopt a Workmen's Compensation Law? Today, every state except Mississippi has such a law. Today the outstanding problem in workmen's compensation is how to broaden its coverage to include as nearly as possible all workers and to compensate all types of industrial injuries. My discussion will concern how this coverage has been broadened by the 1943 amendments to our Law.

Only those workers whose employers are subject to the Workmen's Compensation Law are protected by its provisions. By the 1943 amendments the law was made compulsory for all employers of 8 or more persons. It remains elective for all employers of less than 8 persons. When the Act was wholly elective approximately 40,000 employers were subject to its terms. Today there are in excess of 50,000 employers under the Act. The Unemployment Compensation Law is similar to the Workmen's Compensation Law in the respect that it is compulsory for employers of 8 or more persons. It is interesting to note that their records show a registration of approximately 18,000 employers while there are in excess of 50,000 employers now subject to the Workmen's Compensation Law. It is self evident that the majority of these 50,000 or more employers employ less than 8 persons and are subject to it by choice rather than by operation of law.

Originally our compensation law covered only disabilities which resulted from accidental injuries. This was true up until 1937 when a scheduled occupational disease amendment was enacted. Under this amendment disabilities resulting from certain specifically designated diseases, thirty-one in number, were made compensable. The protection established by this amendment was limited. For example, a grinder who was totally disabled

from pneumoconiosis was entitled to compensation; on the other hand a moulder who worked in the same room exposed to the same hazard who was totally disabled from pneumoconiosis was held outside the scope of the schedule and not entitled to compensation. Furthermore, dermatitis venenata was compensable under the schedule only if it resulted from "any process involving the use of or direct contact with acids, alkalis, acids or oil, or with brick, cement, lime, concrete, or mortar capable of causing dermatitis." Thus, a woman who worked in a bakery and who contracted a very severe case of dermatitis as a result of handling corn starch, and a saleslady who contracted dermatitis as a result of handling cheap clothing with various metallic or tinsel features were not entitled to compensation because in neither case was there any evidence presented that the dermatitis was caused by contact with any acid, alkali or oil or with brick, cement, lime, concrete or mortar. Many other illustrations could be made but I believe these will suffice to demonstrate the inadequacy of the schedule law.

The 1943 amendments made two specific changes which immeasurably broadened the types of industrial injuries for which compensation is payable. First, the requirement that an injury be accidental to be compensable was eliminated and second, general occupational disease coverage was substituted for the schedule coverage.

In the Act as amended, the term "injury" has been substituted for the term "accident or accidental injury." We also have this further provision: "The term 'time of injury' or 'date of injury' as used in this Act shall in the case of a disease or in the case of an injury not attributable to a single event be the last day of work in the employment in which the employe was last subjected to the conditions resulting in disability or death." The implication is clear from this language that compensation is to be paid for an injury due to a disease, for an injury due to a single event, and for an injury not due to a single event. In other words, the injury does not have to be accidental and neither does it have to be due to a single event in order to be compensable. Prior to the 1943 amendment a man who slipped and injured his back and was disabled thereby was entitled to compensation because his injury was accidental. Conversely,

a man who injured his back as the result of a straight heavy lift without any slipping or other accidental feature was not entitled to compensation although disabled. Today such an injury would be compensable. Just recently the Commission had a case of a man with a disabling back condition caused by heavy lifting work which had extended over a period of approximately three years. It was not caused by any single strain or occurrence. The Commission held that case to be compensable as the disability was clearly occupational in origin, was due to a hazard of the employment and the amended statute, in the language I read to you a few minutes ago, recognizes that compensation may be payable even though the injury is not attributable to a single event. The Commission also had another interesting case. A man was employed as a laborer picking up cans which had been placed on street corners and filled with waste. He had to lift the cans from the sidewalk up over the side of a truck and dump them into the body of the truck. In the course of a lift he was struck with pain and it was undisputed upon appeal that the strain of lifting the can had caused an injury to his heart through aggravation of a pre-existing heart condition. There was no accidental circumstance involved. The Commission held that this was a compensable case and awarded compensation. This case has been appealed to the Supreme Court.

The occupational disease provision of the law was changed from the scheduled coverage to general or all-inclusive coverage. This was accomplished by the following provision: "The term 'personal injury' shall include a disease or disability which is due to cause and conditions which are characteristic of and peculiar to the business of the employer and which arise out of and in the course of the employment. Ordinary diseases of life to which the public is generally exposed outside of the employment shall not be compensable." The question of what limitation, if any, was affected by the language "due to causes and conditions which are characteristic of and peculiar to the business of the employer" has been the subject of much debate. This language is not entirely new in our law. Under the former or schedule law we had this provision: "The term 'occupational disease' means a disease which is due to causes and conditions which are char-

acteristic of and peculiar to a particular trade, occupation, process or employment." This language differs from that of our present law in the respect that "particular trade, occupation, process or employment" is used in place of "the business of the employer." It was interpreted in a dissenting opinion written by Mr. Justice Butzel in the case of *Kalee vs. Dewey Products Company*, 296 Mich. 540. In that case the employer had a machine for the purpose of filling and labeling bottles. The employe, with her right hand, placed the bottles on a conveyer which carried them to the machine to be labeled and after it was labeled she took it off with her left hand, meanwhile putting another bottle on the conveyer with her right hand. The employe contracted bursitis in her right shoulder as the result of the continuous movement of that shoulder in this work. Justice Butzel did not believe that bursitis contracted under these circumstances was caused by "conditions which are characteristic of and peculiar to a particular trade, occupation, process or employment." He said, "I do not think that bursitis is an occupational disease unless the occupation subjects the worker to a greater hazard thereof than exists in the usual run of employment. The employment in the instant case did not bring about any hazard which would distinguish the tasks she performed from any other non-strenuous employment, and, therefore, her disability is not an occupational disease within the definition of Section I (c)."

It would, therefore, appear that in Justice Butzel's opinion, causes and conditions would not be characteristic of and peculiar to the business of the employer unless they subjected the worker to a greater hazard of the disease contracted than exists in the usual run of employment. While this opinion of Justice Butzel was a dissent from the majority opinion, it is of greater significance than would ordinarily be true for the reason that the majority opinion was based upon certain other language contained in the old law which is not in the present law. I wish to emphasize the fact that Justice Butzel's opinion was not based upon the fact that this employe had bursitis nor even necessarily upon the type of work she was doing. Fundamentally, it was based upon the conclusion that her work did not involve any greater hazard than attended employment in general. For instance, the conclusion might have

been different if it had appeared that other girls doing the same type of work had contracted the same disease thereby indicating that the work did involve a greater hazard than attended employment in general.

The Commission has passed upon this question in a few cases. In one case a woman had been assigned to what was called a burr-bench job. The specific task required the holding of small aluminum castings of various sizes and shapes on a bench with her left hand and filing off burrs from the castings with a small file held in her right hand. She worked on from 300 to 500 castings each day. It was a comparatively easy job at which some thirty women were employed. After doing that work for about six weeks, she developed a soreness and pain in both of her hands. The condition was diagnosed as arthritis and a partial subluxation of the proximal metacarpal phalangeal joints of the thumbs of both hands. The Commission denied compensation finding that the disability was not due to causes and conditions which were characteristic of and peculiar to the business of the employer. It did this because it did not believe that the conditions of the employment subjected the employe to any greater hazard than that which exists in the usual run of employment. In evaluating this decision it is well to remember that the work was of an easy and non-strenuous nature and that it was very difficult to see how it presented an occupational hazard. This case has been appealed to the Supreme Court.

In another case, a woman was assigned to operating a pneumatic drill which was used to drill holes in aluminum skins for airplane bomber wings. She was required to hold the drill in her right hand in a horizontal position, push the drill against the aluminum surface and press the trigger of the drill with the fingers of her right hand. She performed this operation continuously eight hours a day, six days a week. After doing that work for a few weeks her right hand and arm became painful and in time disabling. Her condition was diagnosed as writer's cramp. The Commission found that this case was compensable on the basis of its belief that the requirements of the employment subjected the employe to a greater hazard than was present in the usual run of employment. Upon the facts as they appeared in the record, the work which this woman was doing

appeared to the Commission to present a definite hazard of disability because of the continuous contraction of the muscles required.

There is reason to believe that the language "due to causes and conditions which are characteristic of and peculiar to the business of the employer" is merely descriptive of the well-established requirement that an injury to be compensable must be caused by the employment. This possibility is indicated by the fact that the Court has in the past used the words "peculiar to" as well as "characteristic of" in describing the statutory term "arising out of the employment." In my opinion, the cause of the disease is the all-important factor in determining whether or not it is compensable. If the disease is caused by the employment and is due to a definite hazard of the employment, it is occupational and should be compensable.

In considering the interpretation which is to be given the occupational disease law, it is well to bear in mind the purpose of workmen's compensation and also its limitations. I have not heard any objection from industry to the proposition that all injuries and diseases which legitimately are caused by hazards of the employment should be compensable. On the other hand, it must be remembered that workmen's compensation benefits are not intended as, and should not be a substitute for, sickness, old age and unemployment insurance. It should not be a blanket insurance, forcing upon the employer the chronic ailments naturally accruing to the human family entirely apart from their labor and hastened by advancing age. Where you have disability resulting from an accidental injury, the relationship between the disability and the accident is self evident in nearly all of the cases. There is very seldom any question of causal relationship and there is very little possibility of the employer having to pay general health insurance under the guise of workmen's compensation. However, where you have disability resulting from a disease or from a succession of events rather than a single event, the problem of causal relationship is more complicated. You do not have anything as definite and tangible as an accident to tie to. You have to rely upon reasonable deductions from the surrounding facts and circumstances and a greater degree of judgment is required. To illustrate, let us suppose

that an employe begins to complain of difficulty in his shoulder with limitation of motion of his arm. Your first step is to ascertain the type of work he was doing. If such work did not involve any unusual use of his arm and shoulder, you would probably conclude that the disability was not related to his work. On the other hand, if his work did involve some unusual motion of his arm and shoulder you would probably be ready to concede the possibility of a relationship between the work and the disability but you still might not be convinced if the same disability had not set in with other workers doing the same kind of work. Of course, if several workers should come in with the same type of complaint, who had been doing the same work, you would then probably conclude without question that the disability was occupational. You have had to search for your answer as distinguished from the case of the employe who slips on an oily floor and breaks his leg.

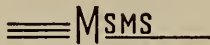
In another situation let us suppose that an employe comes in with a hernia. Again your first step is to determine the nature of his work and conclude whether or not in your own judgment the hernia was attributable to that work. If the work involved continuous and heavy lifting you will probably conclude in the affirmative. If he did nothing but light work your conclusion would probably be in the negative. Some place in between there can be room for a difference of opinion and the evidence will not be as convincing one way or the other.

I might draw another comparison from outside in the workmen's compensation field. We have all heard about murder cases in which convictions were obtained upon circumstantial evidence. Some states that provide a death penalty for murder exclude those cases where the conviction is based upon circumstantial evidence. This quite naturally is because the state feels more secure in its position if it has direct eye witness testimony to what happened rather than having to rely upon the surrounding facts and circumstances to prove its case. However, that does not mean that circumstantial evidence is not good evidence or that convictions should not be based upon it. Otherwise, it would be a very rare situation if anyone were ever convicted of a crime.

Similarly, in the workmen's compensation field,

if you have an accident you generally have direct and tangible evidence and can feel secure in your finding of casual relationship. If you have a disease or an injury not due to a single event you many times have to rely on circumstantial evidence from which to draw your conclusions and the evaluation of such evidence calls for a greater degree of judgment and presents a greater possibility of error than was present in the old standard accidental injury case. However, that should not mean that such injuries should not be compensable any more than that a man should never be convicted of murder unless some one had actually seen him shoot the gun.

If the determination of these questions is kept in the hands of competent persons of good judgment who know the difference between speculation and proof, there is no need to fear an overlapping of health insurance and workmen's compensation. Of course, mistakes will always be made even by the most competent but there is no reason for them to be prevalent enough to disturb the broad picture. The administrative picture in Lansing is very encouraging. Commissioners are appointed for staggered terms of six years each. Inexperienced commissioners are a thing of the past. Each of the present commissioners has had a minimum of four years experience in this work. All of the deputy commissioners are under civil service and all of them have had years of experience. Altogether, they assure competent administration of our compensation law which requires only competent administration and a liberal interpretation of its provisions to be the equal of any in the country.



Paul Mallon says: (August 23, 1945)

The end of the war brought all the patent remedies and isms of the New Deal days out of Pandora's box, winging freely and fluttering loudly, as if they had never been defeated or caged. Even the old-age pension groups (as announced by California's Senator Downey, the Townsend advocate) considered peace the occasion to start what is known as "a drive" for its fandangled economic ideas. A social security fight is the second planned step of the assembling session (hearings next week) and behind it is the cooped-up program to kill free enterprise in medicine by socializing doctors, provide golden spoons for all mouths from the cradle to the grave, and such.

Selective Placement of Workers

A Medical Man's Viewpoint

By F. E. Poole, M.D.

Medical Director, Lockheed Aircraft Corporation
Burbank, California

SELECTIVE placement of physically substandard workers is now an integral part of Industrial Medicine.

Wartime necessity has expedited the development of a method for the placement of the worker so that he may be most fully utilized without hazard to himself or others.

The viewpoints of the personnel manager and the industrial physician differ with regard to placement. The personnel manager is concerned with securing employes with the requisite job skills; the industrial physician is concerned mainly with the employe's ability to work and the amount and kind of work he can be expected to do safely.

From the medical man's point of view, selective placement is the process of evaluation of the worker's physical capacities and mental adjustments, so that he may be properly classified to insure maximum protection and utilization. The physician's decision is based on findings of the pre-employment physical examination, supplemented by laboratory aids, such as urinalysis, audiogram, electrocardiogram, and x-ray.

Accepting the modern and correct principle that the pre-employment examination should not be used for the purpose of weeding out all but the physically fit, it is nevertheless necessary to segregate those workers having communicable diseases, nervous or mental disease, and serious organic disease or physical disability which render them unfit for active work. Such rejections average from 3 to 5 per cent of applicants examined. They may be classed in two ways: those with correctable defects who may be considered later, and those with progressive or permanent disabilities or uncorrectable defects who could never be employed.

The second task is that of proper classification of the acceptable workers. These are divided

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into those available for unlimited work and those having a physical defect or disability which makes certain work undesirable or hazardous for them.

Records covering examination of more than 150,000 workers during the past four years indicate the physically fit group comprises 79 to 85 per cent of all applicants, and the limited group between 12 and 16 per cent. It is this latter group with which we are concerned almost exclusively in selective placement.

Before discussing methods used for classification and placement of employes having defects or disabilities, it should be pointed out that such a program will succeed only insofar as it is understood and applied by supervision. The medical department's participation must be in an advisory capacity to supervision, and final responsibility for the proper use of employes rests with the employe's immediate supervision.

Prior to 1942 the available labor force included sufficient physically fit manpower to permit high physical standards of acceptance. It became evident at that time, however, that the military forces sooner or later would probably drain off a large portion of the physically fit men and that industry, faced with a gigantic war production schedule, would necessarily have to tap other sources of manpower to meet its need. The program developed at that time, and since widely adopted by various industries, was created to permit the greatest possible absorption by industry of workers previously held to be economically unemployable.

To secure maximum efficiency of employment, the program restricted the employe only by prohibiting him from performing work which would be hazardous to him, or in which he would create a hazard for others. Thus, the limited employe is permitted to do any work which does not require the performance of a specific activity for which he is not physically qualified. With a classification system and proper placement the employe and the company are fully protected.

A limited employe, properly placed in a job conforming with his limitations, is as capable of performing that job as any other employe would be; in fact, a "handicapped" employe, properly placed, ceases for all effective purposes to be handicapped. This is the medical man's goal in selective placement.

Since it is undesirable to inform supervision

as to the nature of the limited worker's disability, a subject which subsequently will be discussed at greater length, and since the supervisor's ability to make correct placement depends entirely on his ability to understand the limitations, it was found desirable to create a limitation code easily understood by lay supervision.

Limited employes were, therefore, placed in one of six categories; these are:

CLASS I—*No Hazardous Machinery.*

An employe limited to Class I is not permitted to operate hazardous power-driven machinery at any time.

Hazardous power-driven machines might include: saws, routers, lathes, shapers, mills, grinders, drill presses, hand drill motors (when using extension drill), jig borers, power brakes, drop hammers, punch presses, shears, radial drills, et cetera.

Some non-hazardous machines which those limited to Class I may operate, if proficient, include: tube benders, rivet guns, nut runners, polishing wheels, hand-drill motors (using stub drills), numbering machines, metal benders, metal stretchers, burring tools, et cetera.

CLASS II—*No Heavy Lifting.*

Men limited to Class II are not permitted to lift more than 25 pounds at any time. Women are prohibited from lifting more than 25 pounds under any conditions; when limited to Class II they are not permitted to lift more than 10 pounds.

Constant lifting is more hazardous than occasional lifting. If lifting is required more than six times per hour, men limited to Class II should not lift more than 15 pounds at one time. Women limited to Class II should not be required to do constant lifting.

Carrying is more strenuous than lifting. Men limited to Class II should not be required to carry more than 15 pounds—never more than 10 pounds when carrying up and down stairs. Women limited to Class II should not be required to carry any weight up and down stairs.

CLASS III—*Ground Level Work.*

An employe limited to Class III is not permitted to work on ladders, scaffolding, airplane wings, temporary jigs, or in any other high, unprotected place where a fall would cause injury.

Second and third floors of permanent, protected jigs and buildings are not considered hazardous for Class III limitation. Walking up and down stairs to and from such a place of work is not a violation of the limitation.

Movable steps, ramps or raised platforms designed to facilitate working in permanent jigs and fixtures, are not considered hazardous.

CLASS IV—*Avoid Contact with or Exposure to (agent to be specified).*

When this limitation is applied, the specific agent, such as vapors, dust, or materials known to cause

allergy, is designated. Contact with, or exposure to this agent is thereafter forbidden.

CLASS V—No Extensive Walking or Standing.

An employe limited to Class V is not permitted to walk or stand more than 50 per cent of the working shift. Sedentary bench or desk work is preferable. Work permitting alternate sitting and standing is also desirable.

Constant standing or walking for long periods, although the total walking time may be less than 50 per cent of the working shift, is not satisfactory. For example, a dispatcher or mail collector who makes two 15-minute routes per hour and is seated during 30 minutes per hour, cannot be limited to Class V.

CLASS VI—Special and Miscellaneous.

All conditions which require limitation and which are not included in the first five limitations are placed in this category. When this class is used, the specific nature of the limitation must be stated; for example, an employe who may be harmed by exposure to noise would be restricted by CLASS VI—*Must Work in Noise-free Area*.

These classifications have been found to be adequate for many industries. They are not static, however, and may be modified or revised to suit local situations. For better understanding, the number of classifications should be held to the minimum.

As previously mentioned, the keystone of any medical classification program is the pre-employment examination. This is performed by a medical doctor, assisted by technicians. The principal aim of the examination is to record and describe in detail any defect or disability presented by the applicant. Limitations are applied as necessary, based on the findings of the examination.

Limitations, when necessary, are applied not because of some specific defect or disability but because of a deficiency in the applicant's capacity which renders him unable to perform certain types of work with safety. This requires clinical evaluation of the whole person and limitations must be imposed in the manner required to meet the needs of each particular individual.

The previous medical history, as given by the applicant, is carefully considered during the examination, even though experience indicates that the majority of workers tend to reply to specific questions in the manner most favorable to them.

Employes having serious visual defects, diabetes, heart disease, epilepsy, ataxia, and similar ailments are placed in Class I. Those having

hernias not properly supported by a truss, back and joint lesions, heart disease, arrested tuberculosis, pelvic disorders, and disabilities of this type, are limited to Class II. Those susceptible to syncope or vertigo from any cause, or having deformities or limitations of the extremities, diabetes, heart disease, etc., are placed in Class III, while those suffering from chronic upper or lower respiratory infections or allergies are assigned to Class IV. Back lesions, varicose veins, lower extremity disabilities, artificial limbs, and heart disease are among the reasons for imposition of Class V. Class VI, the special and miscellaneous category, includes such complaints as otitis media, epicondylitis, ganglia, tenosynovitis, neuroses, nervousness, and certain pelvic disorders.

Employes returning from prolonged absence after surgery are limited temporarily according to their condition; generally, they are placed in Class II, to avoid the possibility of strain and in cases of gynecologic or lower extremity complaint, in Class V also.

Pregnant employes are permitted to work, if they are able, until the seventh month, and they are protected during this period by the imposition of limitation to Classes II and III, and if necessary V.

The medical department's responsibility, however, cannot end with the proper classification of the employe. Contrary to opinion held a few years ago, experience has proved that the limited employe is the continuing responsibility of the medical department throughout his employment. To assure proper placement, the medical department must control it, not only at the time of employment, but in the case of subsequent inter-department transfer or job change.

The control of the program requires placement analysts trained in placement methods and having intimate knowledge of all the physical requirements of jobs throughout the plant. They must be in constant contact with supervision for the purpose of assisting in correct placement. The limited employe is referred to an analyst before reporting to work. He contacts the employe's department, explains the nature of the limitation, and determines the requirements of the job. When these requirements are within the employe's capabilities, he is approved for the job. When he is unable to perform the job requirements, replacement is necessary.

A follow-up on this placement is necessary to determine that the employe has been assigned to the job for which he was approved and that the job conforms with the requirements given the analyst. When variations are found, the employe must be transferred to suitable work.

Production requirements result in frequent changes of work conditions in modern industry, and the analysts are available to supervision for assistance in the replacement of limited employes displaced for this reason. In such cases control is maintained by approval of the transfer by the placement analyst.

The employe's physical capacity, too, is subject to change; therefore, re-evaluation of the employe is also the responsibility of the medical department. When the employe's capacity has deteriorated, additional limitation may be necessary, but when the cause of limitation has been removed, limitation can be lifted. When limitations are changed, the employe's work must be rechecked by the analyst, as a change of jobs may be necessary to conform with the new limits.

Employes whom supervision feels are unable to perform their work, or who themselves complain of physical incapacity, are also referred to the medical department for re-evaluation.

Control of limited service placements by the medical department, however, minimizes in no way the importance of the supervisor as the final authority in the placement program. It is necessary, therefore, to keep supervision informed of all new developments in the placement field, and to do this a continuous educational program is required.

Expanding production facilities have required an increase in supervision, and many supervisors have been advanced from the ranks, not because of their ability to supervise and direct others, but because of their familiarity with the work and the extreme need for trained workers to direct production processes. Such supervisors naturally are not prepared to cope with the intricate problems of employe placement, especially when complicated by factors of defect and disability.

On the whole, supervision has done a good job of using available manpower during the war-time crisis. It is to the credit of these harrassed and over-worked leaders that they have been able to do so well, and have willingly accepted

the assistance of those trained in special problems such as labor relations, safety, training, and medical placement. This is indicated by the gratifying enthusiasm with which educational material on the subject of placement is received by supervision.

There is much room for improvement, however, and industry would do well to begin immediately an intensive program of supervision education in all matters relative to the proper placement of employes. Whether we like it or not, in the post-war era industry must accept ever-increasing numbers of handicapped and limited workers. Unless industry learns to use them properly, confusion and discord will result.

Now is the time to begin postwar supervision training, and efforts expended in this direction will be amply repaid in the future.

Such a training program does not seek to convert the supervisor into a medical examiner or a psychiatrist. Its aim is to inform him of basic principles which he can follow in handling employes, and to point out to him the danger signals which should warn him that the matter is one for professional consideration.

It must be assumed that the supervisor is thoroughly acquainted with his production processes; that he is completely familiar with the work being done and the methods used to accomplish it. The placement training program should seek to inform him as to the best methods of applying his human resources to these production processes and methods.

The most important factor with which the supervisor must be made familiar is the employe's mental attitude, especially his attitude toward his work. Our newspapers have many accounts of seriously injured people who, because they had the proper attitude toward their work, have been successful despite their handicaps. Our hospitals have many people, who although physically fit, are mentally unable to adjust themselves to any work attitude.

Every physical defect carries a compensating mental attitude. Those whose mental attitude is not damaged can be rehabilitated and made self-sufficient. Where the employe's attitude suffers as the result of injury, rehabilitation is extremely difficult, if not impossible. In a capsule, where the limited employe's will to be self-sufficient is strong, the possibilities for his successful employment are great.

Even the most ambitious limited employe, however, may be subject to minor mental maladjustments which, if permitted to develop, may mar his efficiency. The same is true of all employes, but applies especially to the limited ones. We must teach the supervisor to be constantly alert for any signs of such maladjustment.

Indoctrination of supervision must be carried on continuously. After supervisors have undertaken a comprehensive training course, it is necessary to keep the subject of placement before them by means of regular discussions, literature, and of course, direct contact.

One great benefit derived from the system of direct supervision contact, previously mentioned, is the elimination of the all-too-prevalent feeling on the part of the supervisor that the medical department's job is to interfere as much as possible with his use of employes, and to place as many obstacles as possible in the way of getting his job done.

When this limitation program was instituted, this feeling was quite prevalent. The medical director was looked upon as an obstructionist by many supervisors. In this, the employment of limited workers, which is a comparatively recent development in industry, parallels the industrial safety program now accepted as a basic responsibility of industry.

Many years ago, when industry began to realize that industrial accidents lowered production efficiency and increased costs, the safety engineer was not accepted by supervision. His plans for protecting workers against hazards were contemptuously termed "molly-coddling." Years of education, backed by undeniable statistics, have proved that safety pays. Today, the foreman who ignores safety and good housekeeping does not last long in a well-run plant.

The limited worker program is now where the safety program was some years ago. It has had tremendous impetus from the war effort, but far too many supervisors still consider placement designed to protect the worker's health as "molly-coddling."

Having convinced the supervisor that we are not obstructionists and that the limited program must be solved, we find he will turn to us automatically for assistance so that he may obtain maximum manpower efficiency. Here is where our direct contact approach pays off. Our place-

ment analysts are available to the supervisor at any time, and he, therefore, refers most matters of placement to them.

The supervision contact program cannot be spasmodic. We cannot give the supervisor an injection of enthusiasm and then neglect him until time for the next shot. It is a day-to-day program which must be carried out continuously, maintaining the supervisor's willingness to co-operate.

It is surprising how much greater success can be obtained in placement by direct contact methods. Frequently, supervisors who may reject a limited employe sight unseen, can be "sold" by direct contact. The analyst does this selling job. He explains the employe's limitations to the supervisor and convinces him of the employe's ability to do the job although limited, if this is the case.

Employment possibilities for limited employes are also increased by direct contact, as analysts frequently disclose many jobs suitable for these workers which supervisors have overlooked.

The results of direct contact methods can be proved. When first undertaken, the heaviest concentration of limited employes in any department was about 15 per cent with a plant average of 10 per cent. A recent check revealed a number of departments having as high as 24, 25, or 26 per cent limited employes, and the plant average increased to 14 per cent. This gain was made during the period when the employment of women increased coincidentally to 40 per cent of the work force.

It is obvious, therefore, that direct contact between supervision and the medical department is essential to any successful placement program. Since 1942 more than 10,000 limited employes have been accepted under the program described, and experience gained can be applied to problems which industry will face in the future.

It is the consensus of most industrial physicians that the postwar problem causing the greatest concern at present is that of re-employing returning war veterans. The word "re-employment" is used in preference to "rehabilitation" as it more clearly describes the problem. Re-employment means the process of putting the veteran back on the job.

It has been estimated that approximately 10 per cent of our veterans will have service-con-

nected disabilities, and of this number, 80 per cent—by far the largest majority—will be capable of returning to the jobs they left, or comparable ones. Only 15 per cent of the disabled group (1.5 per cent of all returning veterans) are expected to have handicaps which will present placement problems.

Accepting this estimate, and in no way detracting from the seriousness of the problem nor from industry's responsibility for its solution, it seems certain that the limitation system described, with certain modifications, will prove adequate.

Those unfamiliar with the principles of using limited workers in industry are presently concerned by what they believe to be an impending problem of tremendous proportions. Those of us who have worked with the problem do not share their apprehension. The problem need not be as difficult as they believe, and its practical solution is entirely possible without experimentation with novel, untried methods, and especially without further regimentation of returning veterans.

Greater emphasis on the psychosomatic phase of the examination will be necessary. When, through his actions, the veteran comes to the attention of the medical department, we must be prepared to assist him in finding himself.

Here the services of physicians skilled in the art of analytic interviewing will be necessary. The veteran will be referred to one of these physicians who will endeavor to determine the cause of his difficulties and to suggest a suitable course of action to remedy the situation. With the co-operation of supervision, this course of action will be undertaken.

The veteran will remain under the constant surveillance of the medical department and will again be referred for interview at the first sign of further difficulty. If none appears, he will be considered to have adjusted himself properly.

Some psychologists, whose viewpoints lean toward the academic, would attempt by tests and interviews prior to placement to screen the veteran as they would a lump of coal until he falls through the proper hole and lands in the correct niche. Testing is of great value when properly applied, but it is improbable that tests adequate to the solution of all of the veteran's problems have yet been devised. The limitations of the tests themselves usually make this impossible, and

the subjection of the veteran to such an ordeal places primary emphasis on the very factor which must be subordinated if he is to resume his place in society as an ordinary civilian rather than as a "problem child."

The concept of accepting the veteran in the same manner as any other worker is encouraged by the military forces and other governmental agencies which have made a study of the problem. To do otherwise is to encourage him to retain any illusions he might have that he is a special case subject to rules and conditions not applicable to others and entitled to privileges not granted them. It would encourage him to cling to any neurotic tendencies he might have.

Essentially, there is no difference between the returning veteran and other employees, and except for their disabilities, none between limited employees and others; therefore, these employees should be treated in the same manner as the others.

Because of prejudices against the crippled and the handicapped, built up over many centuries past, we must guard against discrimination. The limited employee should be considered on the same basis as any other employee, except for work which he is physically incapable of doing without hazard. Employment policies, physical standards, job classifications, and all other industrial policies which discriminate against the limited employee must be eliminated. The present practice of considering the limited employee, and women too, to be of lesser quality than the unlimited employee must be discouraged, as it is unfounded in fact and discriminatory in principle.

Likewise, limited employees are not deserving of special consideration or privileges, once properly placed. When they can be used advantageously, they are entitled to employment, but when suitable employment is not available, industry should not feel obligated to make work for them. To do so would be to defeat the very basis of constructive limited placement.

Special Privileges

The granting of special privileges, such as super-seniority, preferential transfer, extended placement, or non-severance, removes the limited program from the realm of practical business to the field of social charity, justified only by receipt of a grant-in-aid from the Social Security

Board, the State Rehabilitation Commission, or other public or private charitable agencies.

Some industrial leaders and a number of government and union representatives, motivated by high ideals and in appreciation of the limited employee's contribution to our war effort, may be inclined to believe that industry "owes" something to the limited employee—more than to other employees. Nothing could be further from the truth. While the opportunity was present, industry has given the limited employee a chance for gainful employment. It has paid just compensation for the work it received. Consequently, it has incurred no obligation to these employees except for fair and just consideration in the postwar picture. It has every reason for using limited employees where they can be used, but no reason whatsoever for handicapping itself to the point where its employees are incapable of producing profitably the products which must be sold in the highly competitive postwar market.

Once the principle of special privileges is established, the doors are open to abuse of the privilege. The possibilities for the extension of special privileges are unlimited once we abandon the economically sound principle of using limited employees who, when properly placed, are expected to produce a full day's work, and accept the socialized one of special consideration for them.

As previously mentioned, the basic reason for the pre-employment examination is to detail the employee's defects and disabilities. Its medico-legal importance, however, cannot be overlooked as it forms a substantial record in case of an alleged occupational injury. For this reason the examination must be complete. Usually the applicant is asked to furnish information concerning himself, and the examining doctor is responsible for analyzing this information and detailing all significant findings in order that these may be available for future reference.

Information furnished supervision concerning limited employees is confined to the limitation classes imposed. The diagnosis should not be divulged as this is confidential medical information.

There is another important reason why supervision should not be informed of the diagnosis—access to this information tends to result in discrimination against the limited employee. We know that many persons suffering heart lesions are capable of performing non-strenuous work

over a period of many years; yet, we have found instances where informing supervision that the employee suffered from "heart trouble" resulted in the supervisor's refusal to permit the man to do higher skilled work actually within his physical capacity.

Several such instances convinced us it was not in the best interests of industry or the employee to give diagnostic information of any kind to supervision. It does not aid in proper placement, and the limitation classification alone furnishes an adequate guide to correct job assignment.

The exception is the case where the employee himself raises the issue of his physical ability to qualify for a certain position through a job difference or grievance. In such case the medical department must, of course, furnish all possible information to the proper authorities for reply to the employee's complaint. This is not felt to be a violation of medical confidence as the action is initiated by the employee, and an adequate reply cannot be given without a discussion of the medical background.

We have found disabilities and deformities of a static nature, such as loss of an arm or leg, a hand or an eye, to cause less difficulty in placement than those subject to aggravation or of a degenerative nature. The man who has lost a leg, when properly placed on a job which does not require use of the leg, is for all practical purposes as capable of doing that job as any other employee, and any other man with a similar disability and equal skill can do the same job.

This is not true of such degenerative conditions as heart disease, tuberculosis, diabetes, and epilepsy. In such instances each employee must be placed individually with full consideration of his individual capacity. It is for this reason that such cases present the greatest placement problems.

Industry has always been concerned lest the employment of handicapped workers result in increased industrial compensation rates. While this feeling generally is unfounded, it is nonetheless true that the risk entailed in the employment of workers with degenerative disabilities is far greater than those having static handicaps. Statistics prove the frequency of second injuries is very low, but we are all familiar with the number of cases where a pre-existing, non-occupational con-

dition has been aggravated and has become an occupational responsibility.

When such cases are the result of the aggravation of arthritis, neuritis, osteomyelitis, or similar diseases, the implications can be serious and costly. Determination of when such a condition has been restored is a fine technical point which quite frequently must be carried to the Industrial Accident Commission for decision.

This should not be construed as advocating that those with degenerative conditions are unemployable. Such employees can be used by industry in greater numbers and to good advantage without unfavorable compensation experience; however, this is possible only when proper examination, classification, and placement methods are followed.

Summarizing the medical man's point of view of selective placement, the industrial physician is now able to select workers without physical impairment who are capable of performing their jobs without limitation and of classifying those who may have some physical disability or defect so that they may work without increasing the hazard to themselves or others; that a simple system of classification, easily understood by lay supervision, is desirable for limiting physically substandard employees; that the medical department should maintain constant surveillance over the placement and use of such employees; that the continuous direct contact method is the desirable procedure in any system of placement; and that supervision should be trained to carry out its final responsibility for the proper use of limited employees.

Through the program described, with proper examination, classification, and placement, industry in the postwar era can absorb many thousands of substandard workers without unfavorable experience, and the know-how we have gained during this wartime emergency will lead to the development of a satisfactory system for the re-employment of returning war veterans.

The medical man's goal in selective placement is the use of all employees in such an effective manner that the maximum number of people may be gainfully employed at all times. As for limited workers, when properly placed, and without discrimination against them nor special privileges for them, they must be considered an important segment of our increasingly productive American work force.

Psychosomatic Medicine in Industry

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IT is, I think, very timely in this symposium on Postwar Problems of Industrial Health and Medicine to include some consideration of psychosomatic medicine and its relation to industrial medicine.

Wars are, quite properly, considered by all intelligent people as wasteful, destructive, and degrading. That they are at times resorted to is one of the tragedies of our civilization. Apart from the successful defence of our ideals and our way of life, we can point to few advantages which can be gained from modern warfare. There are, however, a few entries on the credit side of the ledger and one of these is the stimulus that wars give to scientific thought and progress.

Each war of the present century has resulted in important advances in the field of medical science. Out of the present conflict is emerging a new concept of health, a tendency to regard health as a positive condition rather than the mere negation of disease. Together with this, we are realizing the importance of studying the patient as a human being rather than as a conglomeration of diseases: to consider his personality, background, and environment in its relation to his symptoms and physical condition. To this study has been applied the term "psychosomatic medicine" and I believe that it constitutes a most significant trend in modern medical practice.

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Living in a wartime atmosphere as we are at present, one may perhaps be excused for drawing an analogy between the warfare waged by medical science against disease and that conducted by our armies along the Rhineland front. Our armies in the field are organized into corps, divisions, and special combat groups, each with their own special arms and type of equipment to perform a certain function. Medical science also has its organized groups each trained to use its specialized weapons in the form of diagnostic procedures, laboratory tests, and various types of therapy. While the objective of our armies is the destruction of the enemy forces, that of our profession is the conquest of disease and the promotion of health. Although we are continually advancing toward this objective, it will be noted that this advance is not an even advance all along the line any more than that of General Eisenhower's armies. From time to time due to some particularly able general, some new weapon, a clever piece of strategy or some newly discovered weakness in the enemy line, spectacular gains may be scored. These gains, however, cannot be consolidated or fully exploited until the rest of our forces have moved up in support.

In the practice of medicine, a new discovery or the application of a new type of therapy may result in a rapid advance in our methods of treating certain types of disease. If, however, the rest of our "line" does not move up in support of this advance the advantages gained do not become fully effective. In fact a dangerous "salient" may be created.

During the past fifty years or more, as a result of the rapid increase in scientific knowledge in the fields of pathology, physiology, chemistry, medicine, and surgery, the practice of medicine has become "sectionalized." This has been described as the "mechanized age of medicine." There has been a growing tendency in the past to treat diseases rather than patients. Medical teaching has also become sectionalized and students are taught their preclinical and clinical subjects in separate "compartments" without very much relation to the patient. This is a condition which is recognized and deplored by many of our best medical teachers. The fact is that before a student graduates and frequently for some time after graduation, he sees little relation between the disease he is studying and his patients

as individuals. We note a growing tendency toward specialization in the narrowest sense which in many cases consists of the treatment of one type of disease or one group or organs only.

Psychosomatic medicine as its name implies means simply the addition of the knowledge and techniques of psychiatry to our knowledge of medicine and surgery. To continue our analogy, we might compare the advances made by the "mechanization" of medicine to the spectacular break-through of General Patton's tank forces. But just as the mechanized army requires infantry reinforcements to consolidate its position so the mechanical techniques of medical practice require the human techniques of the psychiatrist to reinforce them and render them fully effective.

Although psychosomatic medicine is a new term, it is actually merely the revival of an old principle and one which was practiced very successfully years ago by the old-fashioned family doctor in the days when medicine was an "art" and not a "science." Although he did not call it such, the family doctor practiced psychosomatic medicine. He was able to do this because of his intimate knowledge of the patient, the patient's family and his whole environment. Perhaps that is why so many people make such sympathetic and affectionate reference to the old family doctor.

The status of the industrial physician as a specialist is still the subject of controversy. Inasmuch as industrial medicine is the application of medical science in a special field and requires a special knowledge and skill, it is a specialty and a doctor devoting his full time to this specialty may properly be regarded as a specialist. Industrial medicine, however, differs radically from most other specialties where the interests of the doctor tend to become narrower and narrower in concentrating on one disease or one type of treatment. Whereas such a specialist must know a great deal about a few things, the industrial physician must know at least a little bit about a great many things. Whereas the horizon of the other specialist tends to become progressively narrower, that of the industrial specialist broadens as new industrial processes are developed and new medical discoveries are made. The interests of the industrial doctor must include not only the diagnosis and treatment of disease but a full knowledge of the whole work environment, the manufacturing processes, and the special health

hazards peculiar to his industry. In fulfilling his part in accurate job assignment and in making his contribution to the organized operation of the industry, he must consider not only the actual physical condition of the workers under his care but their personality, mental attitudes, intelligence, and the manner in which they react to their job, their fellow workers, and their supervisors. If a visiting nursing service is maintained and is functioning properly, the doctor also has an opportunity, through his nurses, of gaining valuable information about the home environment of his patient. In fact, the work of the industrial physician in his intimate contact with his patients and his knowledge of their work and home environments in many ways approaches closely the role of the old-fashioned family doctor in his patient-doctor relationships. For this reason, the industrial physician is in an exceptionally favorable position to practice not only preventive medicine but to apply psychosomatic principles in the diagnosis and treatment of those under his care.

Weiss and English in their text book on psychosomatic medicine make the following statement:

"Between the small number of obviously psychotic persons whom a physician sees and the larger number of patients who are sick solely because of physical disease are a vast number of sick people who are not 'out of their minds' and yet who do not have any definite bodily disease to account for their illness. Psychosomatic medicine is chiefly concerned with them (Group 1). It is reliably estimated that about a third of the patients who consult a physician fall into this group. These are the so-called purely 'functional' problems of medical practice.

"Approximately another third of the patients who consult a physician have symptoms that are in part dependent upon emotional factors, even though organic findings are present (Group 2). This second group is even more important than the first from the standpoint of diagnosis and treatment. These psychosomatic problems are often very complicated and, because serious organic disease may be present, the psychic factor is capable of doing more damage than in the first group.

"Group III comprises a group of disorders generally considered wholly within the realm of 'physical disease,' which have to do with the vegetative nervous system, such as migraine, asthma, and essential hypertension. Psychosomatic medicine is much interested in these disorders because it believes that the psychic factor may be of great importance in their etiology and, even more importantly, in their management."

I do not think these figures are exaggerated and if applied to industrial medical practice will be found to err on the conservative side. The absence of monetary considerations in the patient-doctor relationships in industry encourages workers to report symptoms early and to report minor complaints for which they probably would not consult an outside doctor.

As a result of safety program and concentrated accident prevention campaigns much has been heard of the accident-prone individual. This proneness to accident is in the majority of cases due to some psychiatric disturbance. Less has been written and said about the sickness-prone worker. This type of patient falls into three main groups:

1. Those unfortunates, who, due to poor physique, bad heredity, unhealthy home environment, some constitutional weakness or just bad luck, suffer from a succession of organic diseases.
2. Those who complain of a multitude of symptoms often quite unrelated and who are actually ill, yet for whom no organic cause can be found to explain their condition.
3. Those who suffer from some actual organic disease but whose symptoms are exaggerated and their illness complicated by some psychic factor or factors.

The individuals in the two latter groups constitute one of the greatest problems of the medical profession, industry, and the whole community. It has been estimated that in the case of accident-prone workers, ten per cent or fewer of the working force may be responsible for 90 per cent or more of the accidents. While I cannot quote figures for sickness-prone workers, I would be prepared to argue that a disproportionately large percentage of the sickness lost-time is attributable to a disproportionately small group of workers. The cost of these "functional" complications is out of proportion to the number of workers involved, not only in time lost from work but in doctors' and nurses' time and lowered production efficiency. Many of these sickness-prone individuals are also accident-prone. It is, therefore, obvious that in order to increase the efficiency not only of the industrial medical department but of the whole industry, it is of the utmost importance to recognize these conditions for what they are and take steps to remedy them.

Now comes the \$64.00 question, "What to do about it?" I freely confess that I haven't all the

answers or even very many of them. These cases constitute one of the biggest problems faced by industrial medicine and by industry today. The first and most important thing to do is to recognize that they exist. In the interests of co-operation and good supervision, some understanding of these cases should be conveyed to foremen and supervisors. In the past, it has happened all too frequently that psychosomatic complaints have been described as imaginary. Workers complaining of these symptoms have been dismissed as "lead swingers" or "fakers" and little understanding has been shown of the fact that people demonstrating these symptoms are actually ill and while these complaints may have no organic basis, nevertheless they are genuine complaints. The pain complained of is real pain and those complaining are really ill.

Tensional and anxiety states are responsible for most psychosomatic symptoms and if these conditions are not relieved may actually produce organic disease. Now it may be difficult for a healthy well-adjusted person to understand how a state of mind such as anxiety or emotional tension may cause organic disease. The commonest example of the physical effects of emotion may be illustrated by such simple and well-known phenomena as pallor, blushing, sweating, goose-flesh, and palpitation. These physical manifestations as we well know may be produced by emotional disturbances. In extreme cases, bladder and bowel control may be affected by such emotion as fear or excitement. If these facts are borne in mind, it becomes more readily understandable how an organic lesion such as peptic ulcer may develop under the constant stimulation suffered by the gastric mucosa of individuals undergoing nervous and mental strain.

These tensional states which are, in many cases, produced or aggravated by wartime conditions are more prevalent now than ever before. They are found not only in service personnel but in many civilian workers as well and in the latter case are aggravated by such factors as high taxation with consequent financial worry, housing problems, the worry attendant upon having relatives on active service and the million and one minor hardships and frustrations imposed upon us by war conditions. Workers suffering from these anxieties and mental conflicts with their consequent psychosomatic disturbances constitute

one of the major health problems at present facing industry. These problems will probably not diminish until after the rehabilitation of discharged service personnel has been completed and, of course, will always constitute a serious national health problem.

Although it is difficult to classify them into distinct groups, I believe that these psychosomatic cases can roughly be classed under two headings:

1. Those whose emotional conflict and frustrations are fairly recent in origin and arise from their immediate living conditions or work environment.

2. Those whose psychosomatic symptoms may be attributed to some longstanding condition or set of circumstances and on investigation may sometimes be traced back into the childhood or early environment of the patient.

Cases in the first group are probably most frequent and offer us the best opportunity for successful diagnosis and treatment. If the cause of the disturbances can be recognized and corrected before the condition becomes chronic or before organic lesions develop, these cases can be cured. Those in the second group where the cause of the trouble may be of long standing and obscure in origin are more difficult to treat successfully. They demand a great deal of time and study and usually require the attention of a trained psychiatrist. If, however, these psychosomatic cases are properly diagnosed by the industrial physician and properly understood by the supervisor, a great many may be cured with a resulting reduction in absenteeism and increased production efficiency.

It is an unfortunate fact that, with a few exceptions, psychiatrists have no knowledge of industry and lack the interest in industrial medical problems required to properly treat these cases involving workers and their industrial environment. A knowledge of the industry and the industrial processes is most important. I believe that a thorough understanding of the work environment and the possession of what one may term an "industrial medical attitude" plus plain common sense is more important in treating these cases than a profound knowledge of psychiatry. While this may sound like heresy to the psychiatrist, I think the most practical answer to our problem is to develop in ourselves some knowledge of the basic principles of psychiatry and apply this knowledge to these cases.

In our diagnosis and treatment of these psychosomatic problems, it must be borne in mind that we should have a reasonable basis for making our diagnosis and that in investigating these cases the use of "mechanistic" aids to diagnosis should not be ignored. We should make full use of physical examinations, x-rays, basal metabolism tests, biochemistry, electrocardiograms, and any other means at our disposal to detect or eliminate the existence of organic disease before labeling a condition as functional. If organic diseases exist together with some psychic disturbance we must administer the proper therapeutic treatment as well as apply psychotherapy.

I would summarize my remarks as follows:

1. The psychosomatic approach to the diagnosis and treatment of disease represents a definite new trend in medical science.
2. This is an approach which is particularly applicable to industrial medical problems.
3. The practice of psychosomatic medicine does not imply that we should discard other diagnostic and therapeutic measures which have stood the test of time; rather it involves the reinforcement of existing methods of diagnosis and treatment by the application of a knowledge of psychiatry.
4. Psychosomatic medicine is a new instrument which has been placed in our hands. It behooves us to train ourselves to wield it judiciously and effectively.



REPORT DRUG THIOURACIL NOW CURES THYROID GLAND INFLAMMATION

In *The Journal of the American Medical Association* for September 22, Dr. Brien T. King and Dr. Leo J. Rosellini state that out of eleven cases diagnosed as thyroiditis and treated with thiouracil, eight were symptom-free in one week, and in all the gland enlargement completely disappeared.

Prior to September, 1944, the only treatment that definitely seemed to shorten the course of the disease was x-rays.

In describing the disease, the authors stated that in a considerable percentage of all cases there had been a history of recent mouth or throat infection. The disease is usually of sudden onset, occurring in a previously normal gland or one slightly enlarged. They have not seen it develop in a previously existing goiter of any type. It is associated with slight to moderate enlargement of the thyroid gland, which is usually quite tender and painful.

The Role of the General Practitioner in Tuberculosis Control

By Herman E. Hilleboe, M.D.

and

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HERMAN E. HILLEBOE, M.D.

■ MANY years ago John Bunyan referred to tuberculosis as "Captain of the Men of Death." Although it is no longer the leading cause of death in this country, even a casual glance at recent mortality and morbidity tables reveals that tuberculosis remains in the foreground as a national public health problem. At present, over one hundred million dollars are spent annually for tuberculosis, and yet this disease is not controlled.

Extent of the Problem in the United States

The first step in a decisive attack against tuberculosis is a careful and comprehensive evaluation of the extent of the disease. Therefore, a review of some statistics best defines the actual problem.

An average of 60,000 tuberculosis deaths were reported annually by State Health Departments in the United States during the five-year period 1939-1943. It is a tragic fact that this disease kills nearly one-half of its victims during the most productive years of life (twenty to forty-nine years). Tuberculosis is still the principal cause of death among persons fifteen to thirty-five years of age. During the period 1939-1943

Presented at the Third Annual Postgraduate Conference sponsored by the Committee on Industrial Health of the Michigan State Medical Society, in co-operation with the Department of Postgraduate Medical Education of the University of Michigan, Thursday, April 5, 1945, Detroit, Michigan.

an average of 110,000 new cases of tuberculosis were reported annually to State and local health departments.

Tuberculosis discovered by routine chest x-ray examination has kept more than 150,000 men and women from service in the Armed Forces. These persons must be given careful clinical examinations to identify the open cases. Their contacts should be examined for additional sources of infection.

Over 300 members of the Armed Forces are being discharged each month to the Veterans Administration as a result of active pulmonary tuberculosis. All members of the Armed Forces are given chest x-ray examinations at the time of discharge to discover tuberculosis that may have developed in line of duty and cases that were undetected during induction examinations. Careful supervision of many of these persons and their contacts who are not under the care of Veterans Facilities will be a prime necessity.

Surveys made by the United States Public Health Service with mobile x-ray units among one million adult workers in war industries revealed that nearly 1.5 per cent showed x-ray evidence of pulmonary tuberculosis. The vast majority of the cases found were not known previously to local health officials. By a comparison of the number of new cases reported annually with the incidence of pulmonary tuberculosis estimated from these surveys, it can be assumed that the number of hidden cases of tuberculosis in the general population must include hundreds of thousands of individuals.

One important feature of tuberculosis control has been the lack of sanatorium facilities throughout the United States. Only seven of the States meet the requirements recommended by the National Tuberculosis Association of two and one-half to three beds per death.

Plan of Action

After the tuberculosis problem has been defined, a careful inventory must be made of the facilities and resources for tuberculosis control in the community. With exact knowledge of the extent of the problem, including both what is and what is not being done, it is possible to prepare a comprehensive plan of control. One of the best ways to solve this problem is by the coordinated efforts of private physicians, official

agencies, and voluntary groups. A tuberculosis program cannot be confined to one community and have it operate effectively any more than one can isolate that community from others in matters of business, politics or religion. The effectiveness of a local program is dependent upon the effectiveness of the program in the adjacent communities, the State program, and that of the nation. Since everyone is interested in attaining the same goal, the eradication of tuberculosis, all individuals and agencies must combine their resources to attain an effective program. No single group nor agency is sufficiently wealthy or powerful to control this disease.

The New Program of the United States Public Health Service to Combat Tuberculosis

At present this country is engaged in another world war; therefore, the need for concerted effort is even greater today than it was a few years ago. As an example of how war influences tuberculosis control unfavorably, the tuberculosis death rate in Germany rose from 143 per 100,000 in 1914 to 230 in 1918. Realizing this fact, the Surgeon General established a Tuberculosis Control Section within the United States Public Health Service immediately after Pearl Harbor. The Service used part of its Emergency Health and Sanitation Appropriation to establish this office which worked with State and local health departments and tuberculosis associations to avoid the threatened rise in the disease. With limited funds, this program was necessarily confined to those phases of tuberculosis control that would be of immediate benefit to the war effort. For example, mobile photofluorographic x-ray units were sent into war industries for case-finding of tuberculosis among war workers—an easily accessible group.

With the urgent need of a broad national program, the National Tuberculosis Association sponsored Federal legislation. When Public Law 410 was passed on July 1, 1944, by the 78th Congress, there was included authority to appropriate for the fiscal year ending June 30, 1945, the sum of \$10,000,000 and thereafter a sum sufficient for the prevention, treatment, and control of tuberculosis. As a result of this legislation the program is now being expanded to all phases of tuberculosis control. Such a nation-wide program is necessary to unite and utilize the full

resources of official agencies, voluntary tuberculosis associations, private agencies and individuals.

To be successful, tuberculosis control must include four main features: (1) case-finding, (2) medical care and isolation, (3) after-care and rehabilitation, (4) protection of the tuberculous family against economic distress. Any program which includes these public health measures, supported by research and well-planned health education, can reduce the morbidity and mortality from tuberculosis.

Mass Case Finding

Extensive use of the small film technique by the Armed Forces for their personnel and the United States Public Health Service for industrial workers has enabled the x-ray examination to assume the role it deserves as the strongest weapon in the fight against tuberculosis. Standard x-ray procedure with 14 x 17 inch films, unanimously considered the most accurate method of detecting early pulmonary tuberculosis, has been too costly in material and personnel to use extensively. In the past, private physicians have had to avoid such examinations for many cases due to the cost involved.

Since the introduction of mass radiography, case-finding has been used in large population groups without reference to specific foci of infection. This type of program has been so satisfactory that many physicians have advocated that the entire population be examined radiographically at regular intervals. Such a scheme, however, is difficult and does not appear to be essential for the control of tuberculosis. As in the control of other communicable diseases, it is necessary only to reach a significant proportion of the population within a limited period of time.

There are two sizable segments of the population which may be easily reached by mass radiography. These are: (1) persons admitted to general hospitals, and (2) persons employed in the industries of the nation.

Small film radiography is well adapted to case-finding in general hospitals. No expense is entailed in assembling the people for study. In addition, film interpretation can be done by the staff of the x-ray department. Furthermore, facilities are available for completing clinical examinations and providing care and treatment for ambulatory patients.

The procedure also provides several valuable by-products. Increased accuracy in the clinical diagnosis of chest disease is obtained. Non-tuberculous disease is detected more quickly than before. Finally, and of particular importance, employes and nurses in contact with patients avoid exposure to those who have communicable tuberculosis.

Hodges at the University of Michigan Hospital, Ann Arbor, and Bloch and Tucker at the University of Chicago Clinics and Provident Hospital, Chicago, have been examining routinely all patients admitted to their respective institutions for some time. In Michigan, where the photo-fluorographic process is employed, 9.3 per cent of the patients present abnormal roentgen findings; and about 1.5 per cent exhibit x-ray evidence of pulmonary tuberculosis. In Chicago where fluoroscopy and the sensitized paper method are employed, 1.3 per cent of the white patients and 2.66 per cent of the colored patients have clinically active tuberculosis. From these figures the value of mass radiographic methods in the examination of admissions to general hospitals is evident.

It is hoped that soon all general hospitals will provide routine x-ray examinations of the chest just as they are now making routine serologic tests for syphilis. In 1943, over 15 million persons, not including out-patients, were admitted to general hospitals in the United States. The newly discovered cases of tuberculosis found among these patients would logically be the starting points for the discovery of many other cases.

Hospitals which care for the mentally ill are also ideal centers in which to use mass radiographic methods. In the United States, nearly 500,000 patients are currently hospitalized in these institutions. Chest surveys conducted in Minnesota, Wisconsin and Illinois have shown that from 4 to 10 per cent of these patients have x-ray evidence of re-infection tuberculosis. These people are not only likely to infect fellow patients and the institutional employes with whom they come in contact, but also can, when released, disseminate their disease to the general population.

The second population group in which mass radiographic procedures may be profitably used consists of the millions of industrial workers. As previously mentioned, in this group of adults,

about 1.5 per cent had x-ray evidence of re-infection type tuberculosis of which approximately 65 per cent were minimal, 30 per cent moderately advanced and 5 per cent far advanced according to the classification of the National Tuberculosis Association. This distribution is of interest in view of the fact that minimal cases comprised only 10 to 15 per cent of the first admissions to tuberculosis hospitals in this country in recent years.

Other chest conditions besides tuberculosis were frequently discovered by means of these mass radiographic industrial surveys. One per cent of the films exhibited evidence of non-tuberculous pulmonary disease; about one-half of these were cardiac abnormalities. Some films gave evidence of unsuspected carcinoma of the lungs, many of which were discovered early enough for operative intervention. Certainly no industrial hygiene program can be considered complete unless there is included a routine chest x-ray examination of every employe prior to employment and at regular intervals thereafter.

In addition to mass radiography, several other measures are useful in case-finding. Carefully taken histories and physical examinations are useful in cases having subjective symptoms or objective findings; unfortunately, however, in the early stages of pulmonary tuberculosis both symptoms and physical findings are either absent or often escape notice.

It is recognized that tuberculin-testing surveys of school children have great educational value. They are disappointing, however, as a means of finding many infectious patients, and the cost of finding these cases is excessively high. It is better to concentrate these same efforts on the tuberculin testing of the family and other contacts of known cases. Tuberculin testing is similarly unsatisfactory for the examination of adult groups in which the incidence of positive reactors is high (e.g., older adults in large industries). Little is gained by such testing prior to x-ray examination and valuable time is lost by repeated interruptions of work.

The Family Physician

One of the principal sources of new cases will continue to be the family members of known cases of tuberculosis and of persons recently dead of tuberculosis. One must search among family

associates exposed to active cases of tuberculosis in the home. Tuberculosis is a family epidemic, and it naturally follows that one must seek undiscovered cases of the disease in family groups. Therefore, the family physician has a special responsibility and can play an important part in finding these cases hidden in the families of his private patients.

One must always keep in mind that tuberculosis, in its early stages, may be asymptomatic and that even far advanced cases may present few or no abnormal physical signs. For these reasons, private physicians must consider the possibility of tuberculosis in all patients whom they examine. It is not always possible for physicians to obtain 14 x 17-inch celluloid films of each patient. Today, however, it is possible for a physician to use the tuberculin test routinely and to make x-ray examinations of those with positive reactions. Most pediatricians are now employing tuberculin tests routinely, but this group forms only a small proportion of the medical profession.

The practicing physician will do well to request routinely laboratory examination of the sputum of each of his patients with pulmonary symptoms. Some of these persons will be found to have tuberculosis. Most states provide free laboratory service for such tests.

An example of what can be accomplished in a rural community by private physicians in general practice illustrates the point. In 1929, Dr. E. J. Simons and one of the authors (Hilleboe) conducted a tuberculosis case-finding program in Swanville, Minnesota. It included no new procedures but merely consisted of using all measures known at that time. The background of the situation was an epidemic of whooping cough followed by an epidemic of measles during which one or two cases of tuberculosis were found. Thirty cases of pulmonary tuberculosis were diagnosed, nineteen of which were discovered by using a routine diagnostic procedure and eleven cases were found through efforts to trace the others epidemiologically. Diagnostic problems of the general practitioner are best solved by the adoption of a routine procedure for use in all doubtful cases. This schedule should consist of a careful history and physical examination, daily temperature readings, repeated sputum examinations, tuberculin tests, and various chest roentgenograms. Tuberculin tests and

x-ray films provide adequately for the investigation of the epidemiological features of cases found by the family physician. These procedures will be much more generally used if provision can be made for accurate interpretation of the films without additional expense to the patient or the rural physician. Therefore, consultation services of health departments must be expanded to meet this need.

Physicians working in clinics can also conserve time by establishing a routine clinical procedure. In the past, many clinic physicians have spent unnecessary time obtaining a complete history and physical examination only to follow these with an x-ray film which was interpreted as negative. The procedure should be reversed. Persons with positive findings could then be separated from those with negative findings, and the physician could concentrate his history taking and clinical examinations on suspicious cases. Thus, a clinic physician would be able to see many more patients and improve the case-finding program.

Supervision of Inactive Cases

The supervision of many of the inactive cases discovered in mass surveys will fall to the general practitioner. He will be called upon by thousands of people who have been diagnosed as having pulmonary tuberculosis as a result of mass surveys in the last few years. According to some surveys, over two-thirds of the individuals with minimal pulmonary tuberculosis were diagnosed as inactive and the rest were diagnosed as questionably active or active.

Most of the patients referred to the family physician will be in this apparently well group and will not be willing to stop work. It will be the duty of the private physician to determine the question of activity, and then to recommend sanatorium care, other treatment or just medical supervision. If it has been decided that the case is questionably active, a plan of subsequent study must be worked out.

The physician must often decide if it is advisable for the patient to continue his occupation. Physicians have the confidence of their patients so that they frequently can persuade such individuals to accept decisions that often conflict with the patient's wishes. When a person feels well, it is difficult for him to realize that he should enter a sanatorium. It is the responsi-

bility of the physician to convince these individuals that hospital care is necessary.

Home Care When Sanatorium Beds Are Not Available

Unfortunately, after a physician has made a diagnosis of active pulmonary tuberculosis and has recommended sanatorium care, it may be found that sanatorium beds are not available. Therefore, it is necessary for physicians to care for these patients at home. This means that the physician must employ techniques used in the modern sanatorium including bed rest, nursing care, isolation precautions, and general and personal hygiene. Physicians have the responsibility of preventing extension of the disease in the patient, and also preventing its spread to others in the household. Children especially must be watched closely. It is imperative that they be removed from direct contact if their tuberculin reaction becomes positive.

The public health nurse can play an important role in assisting the physician by demonstrating simple methods of isolation technique and obtaining examinations of family contacts at frequent intervals.

Patients Discharged From Sanatoria

Many patients returning from sanatoria will have pneumothoraces that will require maintenance for several years. This does not mean that every private practitioner must obtain training in the technique of administering pneumothorax, although many have become skillful in this procedure. It does mean, however, that as many physicians as possible in private practice become acquainted with the technique so that each community will have at least one physician skilled in the special treatment of these patients. Therefore, it is important that refresher courses be arranged in various tuberculosis hospitals in the United States, so that physicians can become skilled in the techniques of pneumothorax and the interpretation of chest x-ray films.

Developing Community Resources

As gratifying as it is to know that technical developments provide equipment which can be used to discover the disease in the early stages, it is apparent that the mere discovery of the disease will not stop the spread of tuberculosis.

Once tuberculosis is discovered, the patient must receive proper care to arrest the disease and to prevent its spread.

The benefit of early diagnosis of pulmonary tuberculosis can be realized only if an adequate number of hospital or sanatorium beds are available for treatment of those with remediable disease and for isolation of the infectious patient. These institutions must be supplemented by well-located chest clinics, generous public health nursing services, and accessible laboratory facilities.

It is unwise to emphasize case-finding if treatment is long delayed due to a shortage of sanatorium beds. Once a program is started in a community, immediate plans must be made for a sufficient number of beds. Temporary facilities include beds in general hospitals which can be utilized until tuberculosis hospitals are available. Mass radiography may be employed to advantage in communities with no clinical facilities, if only as a means of arousing the public to demand the construction and maintenance of the necessary hospitals.

Sir William Osler referred to tuberculosis as a social problem with a medical aspect. The problem of patients leaving sanatoria against their physician's advice is a difficult one throughout the United States, and has been for years. Indications are that the reasons are more likely social and financial than medical. Accordingly, a sound medical program must be complemented by a generous plan of public assistance, particularly for the families of dependent tuberculous patients. If this is not done, full benefits will not be realized from the other phases of the program and especially from sanatorium care.

Individual physicians can also stimulate case-finding and follow-up procedures by assisting voluntary and official agencies in obtaining the help of all of the medical profession for such programs. When funds for tuberculosis control are limited in a given community, great care must be exercised in the choice of case-finding procedures. Those methods should be selected which will reach the greatest number of people in the shortest possible time.

As physician, teacher and responsible citizen, the general practitioner of medicine has a leading role in the Nation's fight against tuberculosis. Only with his active support can the community achieve the good results which modern

methods of tuberculosis control offer. Additional facilities to assist the general practitioner in this task will be made available as the national program expands. This joint effort will find its reward in the steady and progressive decrease in the morbidity and mortality from this preventable disease.



WAR MEDICINE

(Continued from Page 1028)

stage, some is being produced and small quantities are being made available to the Medical Department for experimental purposes.

Since streptomycin and penicillin resemble each other in many respects, experience gained in the production of penicillin will aid materially in the production of the new drug. The production process, however, is slow and tedious and it will be some time before the drug is available in any quantity, just as it took more than two years to bring penicillin into production for general use.

ASF CONVALESCENT HOSPITAL CONFERENCE HELD AT PERCY JONES GENERAL HOSPITAL

The Army Service Forces Convalescent Hospital Conference held at Percy Jones Hospital Center at Battle Creek, Michigan, from 20th to the 22nd of August was attended by service command surgeons, commanding generals and their assistants, and representatives of The Surgeon General's Office for a discussion of problems confronting Army hospitals.

Brigadier General Raymond W. Bliss, Assistant Surgeon General, as chairman of the meetings, gave the opening talk. The agenda included talks on medical, surgical and neuropsychiatric treatment, reconditioning activities, classification and counseling, admission, treatment and discharge of patients, problems of morale, leave and furlough policy, and organizational and administrative problems. About 100 officers attended the conference.

PAMPHLET ISSUED ON REHABILITATION OF BLIND

For the assistance of those charged with the care and rehabilitation of blind patients the Army Medical Department has issued a booklet entitled "Guide for Those Giving Rehabilitation Service to the Blind." Its purpose is to anticipate and answer the questions arising in connection with this type of hospital care. The booklet is intended for use in Army hospitals and centers specializing in Rehabilitation Service for the Blind.

It contains information for those actively engaged in working with the blind, and also for anyone who comes in contact with the blind. The booklet gives valuable hints on the psychology of dealing with this handicapped group.

This Year Ahead

The tasks of the presidency of the Michigan State Medical Society, to which position the House of Delegates elected me this month, are always many and important. Ordinarily, one gains much information, knowledge and experience from a year of training as President-Elect; this unfortunately was not available to me, pinch-hitting as I am for our late leader, Vernor M. Moore, who would now be your President, had he lived.

Again, I follow an unusually active President. During his tenure, Dr. Andrew S. Brunk has made the Michigan State Medical Society the clearing house in socio-economic endeavor among state medical societies. As I review his great record of achievement at home and his twelve-month period of medical leadership throughout the land, crystallized in the Detroit and the Denver Medical Public Relations Conferences, I vividly realize the immensity of the job cut out for me—and my own sad limitations.

I enter my term as President of the Michigan State Medical Society with humility and trepidation. However, I am encouraged by the knowledge of the enthusiastic support which all Presidents have received from the other officers and the members of the Society.

I request sincerely that the membership continue their support of their State Society President this year. I invite your advice and seek the benefits of your experience. With these boons, and the expenditure of great effort on my own part, I hope my year may result in some good for the medical men of Michigan and the people they serve.

D. Morrison

President, Michigan State Medical Society



President's



Page



Editorial

NEWLY ELECTED OFFICERS

President

THE ADMINISTRATIVE YEAR 1944-1945 has been unique in the history of the Michigan State Medical Society in that the President-Elect (Vernor M. Moore) died early in his term, leaving a vacancy not provided for in the Constitution and By-Laws. The House of Delegates at its meeting in September elected as President, Ray S. Morrish, M.D., of Flint. Dr. Morrish served in the first World War in France, as Major. He has always been very active in medical administrative affairs, serving his County Society in various capacities, including the office of president. For years he contributed articles about former members of the Genesee County Medical Society to its Bulletin. He has been a member of the Council of the Michigan State Medical Society for several years, the last two of which he served as chairman of the Publication Committee and member of the Executive Committee. His background and training have been thorough and he will make a good President. Our hearty congratulations.

President-Elect

WILLIAM A. HYLAND, M.D., of Grand Rapids, was elected President-Elect. He has served the State Medical Society for years as Treasurer and knows his way as an administrator. He served the full course of offices, including that of president, in his home county, Kent.

Councilors

FOUR COUNCILORS were re-elected to positions they have held before. Philip A. Riley, M.D., Jackson, has served in many positions in Jackson County, and in the House of Delegates, including that of Speaker. He has served on the Council for several years.

Wilfrid Haughey, M.D., is starting his third term as Councilor. He is serving his second "stretch" as editor.

Otto O. Beck, M.D., of Birmingham, is also starting his third term. He has for several years been vice-chairman of the Council, and previously

had been President of the Oakland County Medical Society.

E. R. Witwer, M.D., of Detroit, has completed an unexpired term on the Council. He had been an officer of Wayne Medical Society and president of the American Roentgen-Ray Society.

R. C. Pochert, M.D., of Owosso, retiring president of the Shiawassee County Medical Society, has been very active in medical administrative affairs. He was elected to fill the unexpired term of R. S. Morrish, M.D.

Other Elections

L. G. CHRISTIAN, M.D., of Lansing, and F. E. Reeder, M.D., of Flint, were re-elected as Delegates to the House of Delegates of the American Medical Association.

Howard H. Cummings, M.D., of Ann Arbor, and Ralph H. Pino, M.D., of Detroit, were re-elected Alternate Delegates to the American Medical Association.

P. L. Ledwidge, M.D., of Detroit, was re-elected Speaker of the House of Delegates. He had served two terms with such distinction that he was the unanimous choice for the position.

John De Tar, M.D., of Milan, was elected Vice Speaker of the House of Delegates. During this meeting he served as chairman of a very important reference committee which worked most of the night.

A. S. Brunk, M.D., of Detroit, retiring President, was elected Treasurer of the Society, the office relinquished by the newly elected President-Elect.

The Council met Wednesday morning, September 19, and elected as its officers: E. F. Sladek, M.D., of Travers City, Chairman; Otto O. Beck, M.D., of Birmingham, Vice-Chairman; F. H. Drummond, M.D., of Kawkawlin, chairman of the Publications Committee; Oscar Stryker, M.D., of Fremont, Chairman of the County Societies Committee; E. R. Witwer, M.D., of Detroit, Chairman of the Finance Committee. Dr. Witwer had recently been appointed to this position to replace C. E. Umphrey, M.D., who had resigned as Chairman.

COMPULSORY MEDICAL SERVICE— POLITICAL MEDICINE

ALL THE signs point to an impending drastic change in our social security legislation. The bureaucrats are looking for a place to land where they may continue to be paid for looking after someone else's business. The war effort using millions of bureaucrats is about at an end, and there will be myriads of people looking for steady and easy jobs—the time and opportunity is propitious.

Labor has announced by radio and otherwise a liberal program of social security laws, to include health security, and reportedly is considering both the national and the state level for its activities. We have already had samples of their proposed bills both in Michigan and California.

Politicians also are at large. We have reported Wagner-Murray-Dingell's 1945 version of the social security amendment with especial reference to medical services for all. Also we have reported the Pepper proposal for Maternal and Infant care for all persons of whatever stage of financial ability, giving them free and extended and liberalized EMIC, together with a hospital building scheme to cover ten years and cost \$950,000,000.

The Executive Committee of the Council of the Michigan State Medical Society in February appointed a drafting panel to propose conditions that would be acceptable to the profession in any legislative plan for medical security for the whole people. The preliminary statement was published in our June JOURNAL. On April 27, 28, 1945, the Michigan State Medical Society was host at a Michigan meeting of Presidents and Presidents-elect of seventeen State Medical Societies at which our plan was presented. Another such meeting was held in Denver on June 28-29, 1945, where the Presidents and other officials of ten State Medical Societies were in conference. The groups at both meetings believed some basis should be developed for legislative action of a nature that the profession could support. The proposals made up to date have totally neglected the advice of responsible medical authority, even though their proponents claimed to have so consulted. The fringe mentioned would doubtless be unknown to ninety per cent of our members.

The new Council on Medical Service and Public Relations of the American Medical Association has promulgated a platform of Fourteen Points that the profession can and does accept, and that

should control in all medico-social legislation, or governmental planning. We have recently seen also the statement of the Indiana State Medical Society Drafting Panel, and the Principles of the California Medical Association on Health Insurance (both resulting from the Detroit and Denver Medical Public Relations Conferences.)

The heaven is working, but it must grow much more rapidly. Social legislation is impending, and with the end of the war and the vigorous fight to be made for continuance and extension of benefits, there will be efforts to rush these measures. Their proponents know that the health measures are not satisfactory to the one group of the nation's people who know about such things. They should now consult such trained persons, and we must be ready with suggestions that will be best for the people, will guarantee the best of health care, will preserve independent American Medicine, and will use the least of the harpies who hope to live off the rendering of medical and health service.

We hope every one of the twenty-six states will send in their suggestions at once so that a conference can be held promptly to assemble and publicize the wishes and considered advice of those who know. That does not prohibit any state not so far involved from assisting.

A PLAN OF MEDICAL CARE FOR VETERANS —MORE SATISFACTORY AND ECONOMICAL

THE PUBLIC press for the past few months, the Congressional investigations, and comments in many medical Journals have convinced the public that the medical care of our veterans of the last war has not been up to the standard the great American people should have provided for their sick and disabled fighting men. With thousands already back in civilian life on medical discharges, and with millions about to be released from military service, the Veterans Bureau that had already proven its inadequacy, is swamped. The returned serviceman has his disabilities which must be evaluated before he receives the allotment due him. He also is subject to minor or major ills which send him to the doctor. He believes, as do most of the people, that he is entitled to such services, promptly and skillfully rendered.

The old Veterans Facility Hospitals are scattered all over the country; Michigan has two; one at Fort Custer, Battle Creek, and one at Dear-

born. Both are large, well-equipped, but understaffed institutions, and are fairly inaccessible. The Facility at Fort Custer is six miles from town, on a bus line, and the one at Dearborn is two hours from Detroit, if you know how to make it.

There are three bills in Congress (H.R. 3310, H.R. 3317 and S. 1079) which propose to establish a medical bureau in the department something like the army or navy medical departments. This it is hoped will attract better and more men to the service, and thus give better service to the patients. It will also further reduce the number of doctors available for private practice and care of civilians.

Plans would call for adequate laboratories and research opportunities. The advantages are obvious; better care, research, modern hospitals with the same approval our civilian hospitals are now so jealously enjoying.

But in order to make this service available to all of our returned servicemen now or in the very near future hundreds of these hospitals and medical and surgical staffs would have to be provided. Michigan is certainly inadequately covered (a new Veterans' Hospital is announced for Iron Mountain). These veterans have served their country in places away from home too long already. They are entitled to live at home, to have their home and well-known doctors, their own physicians in whom they have full confidence, take care of them. This the Veterans Administration is attempting to do, but unsuccessfully. The veteran must first visit one of the facilities for examination and determination of treatment, then the bureau contacts his home physician and arranges for certain treatments over a specified number of visits. It has not proven too satisfactory.

The Michigan State Medical Society has suggested that these examinations and the needed medical attention be provided by our voluntary health plan, Michigan Medical Service. It is only necessary for the government to recognize the adequacy and the availability of the voluntary non-profit hospital and medical service plans, and the *advantage and economy* of using them, and the

problem of care of the veteran is solved. Very soon the public may demand that care be made available to the veteran's family. That step will regiment forty or fifty per cent of the people of the nation, and under present plans will call for vastly more hospital facilities and medical personnel than are in existence. The plan to use the Medical Co-operatives, Michigan Medical and Hospital Services, as suggested, will prove highly feasible, will provide sufficient medical personnel, anticipating the release of surplus medical officers in the fighting forces, and will prove much more economical than any plan of regimentation with the resulting administrative bureaus, and uncontrolled spending that has resulted in the past.

The Veterans' Bureau could recognize the advantage of use of existing co-operatives, and could help to get them in operation in states not now supplied. This one step would cure the criticism now so rampant, and would make for the most acceptable form of veterans' care imaginable—the home hospitals, home doctors, visits of family and friends. The hospitals now government-owned could be continued as they are now for use of the chronically ill; those who must be hospitalized over months and years.

The modernizing proposed changes for the veterans' hospitals must be instituted in any event.

ON THE RUN . . .

Because of the potential malignancy of undescended testes even after operative correction, patients subjected to such an operation should have follow-up examination for no less than ten years.

* * *

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* * *

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* * *

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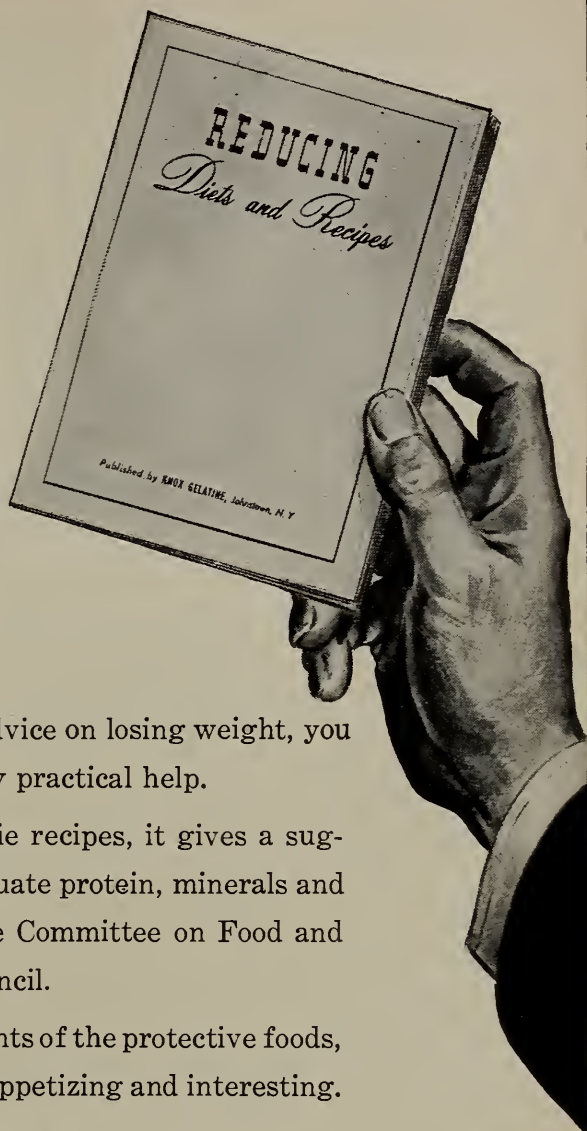
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WHAT TO EAT BEFORE THE BABY COMES

Approved by the Committee on Maternal Health of the Michigan State Medical Society, and by the Executive Committee of the Council.

MILK—One quart a day. Drink it or use it in cooking as in soups, custards and creamed dishes. Evaporated milk diluted with an equal amount of water is equal to whole milk in food value and may be more economical.

American or cheddar cheese has food value similar to milk. 1 oz. ($1\frac{1}{4}$ inch cube) of cheese equals 6 oz. ($\frac{3}{4}$ cup) of milk.

VEGETABLES—Three servings each day in addition to potato. Eat a leafy, green or yellow vegetable daily. Have one liberal serving of raw vegetable.

The leafy vegetables include spinach, kale, beet greens, turnip greens, swiss chard, new cabbage, and wild greens such as mustard greens, dandelion greens, lamb's quarters and sorrel.

FRUITS—Two or three servings each day. One of these should be orange, grapefruit, tangerine, fresh or canned tomatoes. Raw greens, raw turnips or new cabbage may be substituted for tomatoes or citrus fruit.

EGGS—Eat at least one every day including that used in cooking.

MEAT—One liberal serving of lean meat each day, unless your doctor advises otherwise. Liver, kidney and heart are especially good. Fish or poultry may be used occasionally. An additional serving of lean meat, eggs, beans or cheese should be included wherever possible.

DARK BREAD AND CEREALS—Three or four servings of whole grain or enriched bread and cereals every day. Some of the whole grain products are oatmeal, cracked wheat or whole wheat cereals, cracked wheat and whole wheat bread.

BUTTER—A moderate amount (one to two tablespoons) every day. Margarine that has vitamin A added or cream may be substituted.

FISH LIVER OIL—Two teaspoons of standard fish liver oil, or its equivalent, as recommended by your doctor.

FLUIDS—Eight glasses of water every day in addition to milk, clear soups, weak tea, coffee and fruit juices. Alcoholic beverages and soft drinks should not be taken without the doctor's consent.

IODIZED SALT—Iodized salt should be used on the table and in cooking for yourself and the whole family. Salt of any kind should be used sparingly during the last three months of pregnancy. Also during this time avoid salty foods such as bacon, ham, salt pork, salt fish, chipped beef and other salty prepared meats.

Soda should not be used in cooking nor taken without the doctor's consent.

If this diet is not sufficiently laxative, eat more fruits, vegetables, whole grain breads and cereals and take more fluids. A glass or two of hot or cold water and a glass of fruit juice or tomato juice taken about twenty minutes before breakfast is often helpful. Regularity of mealtimes aids digestion and elimination.

If you eat these foods, you may choose the rest of your meals to maintain proper weight gain and to suit your own taste. Omit food which you know disagrees with you. Keep food simple and limit the amount of calorie-rich foods—those rich in sugars, starches and fats such as pastries, cakes, candies, macaroni, rice, spaghetti, gravies, fat meats, salad dressings, fried food, rich puddings and sauces. If your doctor says you are gaining too much weight, omit some of the sweets, gravies, salad dressings and rich desserts. You should not gain more than twenty to twenty-five pounds above your normal weight.

Since it is highly desirable that mothers nurse their babies, choose these same kinds of food during the nursing period but eat them in more generous amounts. Add one pint of milk and another serving of citrus fruit and leafy, green or yellow vegetable, either raw or cooked. These may be eaten at mealtime or between meals.

Sample Meals for a Day (Pregnancy)

<i>Breakfast</i>	<i>Lunch</i>	<i>Dinner</i>
grapefruit	cream vegetable	pot roast of beef
cracked wheat	soup	baked potato
with milk	cooked prune	mashed yellow
poached egg	stuffed with	squash
whole-wheat	cottage cheese	cabbage slaw
toast and butter	salad	gingerbread
coffee, if desired	whole-wheat	whole-wheat
	muffin and	bread and
	butter	butter
	baked apple	milk
	milk	tea or coffee, if
		desired
<i>Mid-morning</i>	<i>Mid-afternoon</i>	<i>Evening</i>
milk beverage	milk beverage	milk beverage

Some Useful Recipes

Cooked Breakfast Cereal

Cracked wheat makes a delicious breakfast cereal. Get a good quality of wheat from a feed store or mill, wash, drain and grind in a food chopper or coffee mill. Use 5 to 6 cups of water and 1 teaspoon of salt to 1 cup wheat. Stir occasionally and cook 15 minutes over direct heat. Place in a double boiler and cook 30 to 45

(Continued on Page 1086)

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SOME USEFUL RECIPES

(Continued from Page 1084)

minutes longer. Flavor is improved with the longer cooking. It may be cooked the night before and reheated in the morning. The cooking time may be shortened by soaking the wheat overnight.

Gingerbread

- 1 cup buttermilk or sour milk
- $\frac{3}{4}$ cup molasses
- $\frac{1}{2}$ cup brown sugar
- 3 cups flour (sifted)
- 1 teaspoon ginger
- 1 teaspoon cinnamon
- $1\frac{1}{2}$ teaspoon baking soda
- $\frac{1}{3}$ cup fat (melted)
- $\frac{1}{2}$ teaspoon salt
- 2 eggs (beaten)

Combine buttermilk, molasses and brown sugar. Add dry ingredients sifted together. Add melted fat and eggs. Blend well and pour into buttered loaf or muffin tins. Bake in a moderate oven 350° F. for 30 to 50 minutes. Muffin size gingerbread will require 25 to 30 minutes. Loaf size tins will require 50 minutes to 1 hour baking.

Cream Vegetable Soup

- 2 tablespoons butter or other fat
- 2 onions (sliced)
- 2 potatoes (sliced)
- $\frac{1}{2}$ cup hot water
- $\frac{1}{2}$ teaspoon salt
- 1 can condensed tomato soup
- 1 cup canned tomatoes
- 1 cup crushed corn
- 1 quart milk
- 1 tablespoon chopped parsley

Cook onions in butter or fat until faintly yellowed. Add potatoes, water and salt. Simmer for 10 minutes or until potatoes are tender. Add remaining ingredients, reheat and serve. Garnish with parsley, toasted bread cubes or chopped hard-cooked egg.

Braised Liver with Vegetables

- 1 pound liver
- 1 onion, diced
- 3 tablespoons fat
- 1 cup tomatoes
- 4 carrots
- 5 potatoes, sliced
- 1 teaspoon salt
- $\frac{1}{8}$ teaspoon pepper

Cut liver in two-inch squares. Roll in flour and brown with onions in melted fat. Add vegetables and seasonings. Pour into greased baking dish, add 1 cup boiling water (more if necessary) and bake in moderate oven, 375° F., until tender—about $1\frac{1}{2}$ hours. This may be simmered on top of the stove. In this case, more water will be necessary.

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In Memoriam

DIED IN MILITARY SERVICE

Walter Robinson Finton of Jackson was born in 1911 and was graduated from the University of Michigan Medical School in 1936. He interned at Hurley Hospital, Flint. Before entering military service, he was associated with his father, in the Jackson Clinic. Doctor Finton was commissioned in the Air Force in September of 1942 and trained at Miami, Florida. He was stationed at the Army Air Base at Walla Walla, Washington, for four months. On June 1, 1943, he was assigned to the Second Air Force and sailed for European duty. He served in England, Ireland, France and Germany. Doctor Finton was stricken with illness in Southern Germany, and died in France on July 15, 1945.

* * *

Francis H. Needle of Pontiac was born in 1909 and was graduated from the Wayne University Medical School in 1939. He was resident physician at the Pontiac General Hospital for one year and was in private practice for two years preceding his entrance into the Navy on April 9, 1942. He was stationed in the Aleutian Islands for eighteen months. He was then sent to Texas for eight months before heading for the South Pacific in October, 1944. He was killed in a plane crash July 27 while serving as a flight surgeon with a rescue squadron.

J. M. Atkinson of Port Huron was born in Eaton, Indiana, August 13, 1897, and was graduated from the University of Michigan Medical School in 1930. He interned for one year at Mercy Hospital in Jackson and served as resident in gynecology and obstetrics three years in Women's Hospital in Detroit. He moved to Port Huron in September, 1934. One of the most active physicians in Port Huron in recent years, he earned a reputation as one of the community's authorities on obstetrics and gynecology.

Doctor Atkinson resigned as president of St. Clair County Medical Society early this year after serving a short time, because of ill health. He died on July 24, 1945.

* * *

John W. Handy of Flint was born in Hartland, Michigan, on October 5, 1852, and was graduated from the University of Michigan Medical School in 1884. He located in Flint in 1885 and served as president of the Genesee County Medical Society in 1918. He was elected to Emeritus Membership in the Michigan State Medical Society, September 19, 1938. Doctor Handy remained alert, well read and interested in public affairs until his death. He was the author of a number of articles for medical journals. He died July 28, 1945.

* * *

Fred D. Jackson of Detroit was born in 1891 and was graduated from the Detroit College of Medicine in 1921. After graduation, he was in charge of the Franklin Street Settlement and later served as assistant professor of medicine at Wayne University. He was a staff member of Alexander Blaine Hospital, and

(Continued on Page 1092)

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IN MEMORIAM

(Continued from Page 1090)

a specialist in internal medicine and obstetrics on the Florence Crittenton and Providence Hospital staffs. Doctor Jackson died July 31, 1945, at the U. S. Marine Hospital.

* * *

Phil H. Quick of Olivet was born January 7, 1867, in Branch County and was graduated from the University of Michigan Medical School in 1895. He opened his practice in Olivet the same year. Doctor Quick was a fine community leader as well as an excellent physician. Among his activities, were twenty years as president of the Olivet State bank, ten years as a member of the school board, several terms as village councilman and many years as health officer. He had just recently celebrated a half-century of service to medicine. At this time he was made an Emeritus Member of the Eaton County Medical Society. Doctor Quick died on August 11, 1945.

* * *

William J. Seymour of Detroit was born in Detroit in 1878 and was graduated from the Detroit College of Medicine in 1903. He interned at St. Mary's Hospital. Doctor Seymour served as a member of the Detroit Welfare Commission for twelve years, and was attending physician at Receiving Hospital for many years. At various times he was chief of the staff of St. Mary's Hospital, Providence, Receiving and Eloise Hospitals. The William Seymour Hospital at Eloise was named in his honor. Doctor Seymour was prominent in both medical and civic circles. He died on August 4, 1945.

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What's What

Socio-Economic

The AMA House of Delegates will meet in Chicago December 3 to 6, 1945.

* * *

"*There is a deliberate campaign* in progress to stam-
pede the law-makers into hasty passage of legislation
containing a number of provisions of extremely dubious
merit."—*Steel*, September, 1945 Number.

* * *

Iron Mountain has been selected as the site for the
new Upper Peninsula veterans' hospital. Plans provide
for a 250-bed general medical and surgical hospital. No
indication has been given as to when construction will
begin or how much the facility will cost.

* * *

The Calhoun County Medical Society is sponsoring a
telephone exchange, and setting up postgraduate courses in
local hospitals for doctors returning from service. These
new activities are in charge of the Society's Executive
Policy Committee of which J. E. Rosenfeld, M.D., is
Chairman. The members of the Committee are: G.
A. Zindler, M.D., C. G. Wencke, M.D., D. L. Finch,
M.D., and A. T. Hafford, M.D.

Meetings

Percy Starr Pelouze, M.D., Philadelphia, Assistant
Professor of Urology, University of Pennsylvania Post-
graduate School of Medicine, will address county medi-
cal societies in each of the following cities:

Oct. 30—Lansing (P. G. Day).

Oct. 31—Bay City.

Nov. 1 (noon)—Alpena.

Nov. 1 (night)—Traverse City.

Nov. 2—Grand Rapids.

Nov. 5—Jackson.

Nov. 6—Saginaw.

Nov. 7—Mt. Clemens (P. G. Day).

Nov. 8—Ann Arbor (P. G. Day).

Nov. 13—Flint (P. G. Day).

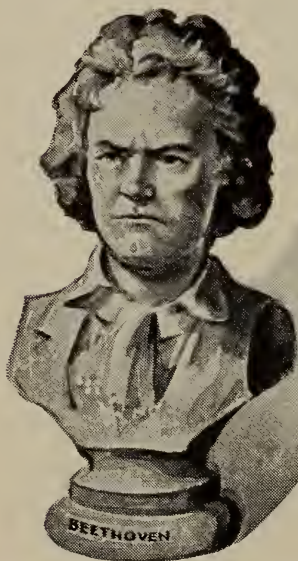
Nov. 14—Battle Creek.

Nov. 15—Joint Meeting, Benton Harbor and St.
Joseph.

Dr. Pelouze's address is entitled "The Modern Treat-
ment of Gonorrhea." He appears in Michigan at the
invitation of The Council and the Committee on Post-
graduate Medical Education of the Michigan State
Medical Society.

(Continued on Page 1096)

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(Continued from Page 1094)



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Conferences on Industrial Medical Relations. Wayne University School of Occupational Health announces a series of conferences on Industrial Medical Relations, designed especially for physicians who participate in or who are interested in the practice of medicine in its application to industrial health. Problems to be considered are those that deal with human relations in industry, and those that pertain to technology and methodology. The subject of the first group of Conferences will be "Human Problems in Industrial Employment."

The Conferences began Wednesday, September 19, Wardell-Sheraton Hotel, Woodward at Kirby, Detroit, 4:30 p.m. EWT, under the Chairmanship of Raymond Hussey, M.D., Dean of the School of Occupational Health. Information on the course may be obtained by writing Dean Hussey at 4072 Penobscot Bldg., Detroit 26.

* * *

The Institute of Medicine at Chicago announces a Conference on Control of Tuberculosis to be held November 13 and 14 at the Palmer House, Chicago. For further information write the Institute at 86 East Randolph St., Chicago 1, Illinois.

* * *

Council and Committee Meetings

1. Executive Committee, Tecumseh, Ontario, August 16.
2. Committee on Medical Veterans' Readjustment Program, Book-Cadillac Hotel, Detroit, September 5.
3. Committee on Rheumatic Fever Control, Porter Hotel, Lansing, September 6.
4. Committee on Uniform Fee Schedule for Governmental Agencies, Detroit, September 9.
5. Special Co-ordinating Committee for Medical Veterans' Postgraduate Program, Ann Arbor, September 11.
6. Publication Committee, Book-Cadillac Hotel, Detroit, September 17.
7. The Council, Book-Cadillac Hotel, Detroit, September 17 and 19.
8. Special Committee on Stimulation of Cancer Control, Book-Cadillac Hotel, Detroit, September 17.

Honors

L. Fernald Foster, M.D., Secretary of the Michigan State Medical Society, has been invited to speak on "Pre-paid Medical Service Plan" in a radio series being sponsored by the AMA Council on Medical Service and Public Relations. John H. Fitzgibbon, M.D., Portland, immediate Past-Chairman of the AMA Council, will also speak on the same program with Dr. Foster.

Other subjects and discussants will be, "What Constitutes Adequate Medical Care?" by Roger I. Lee, Boston, and Thomas A. McGoldrick, M.D., Brooklyn; "What Are Rural Medical Problems?" by R. McVay, M.D., Kansas City and W. R. Brooksher, M.D., Fort Smith, Arkansas; "Costs of Illness" by Louis H. Bauer, M.D., Hempstead, N. Y., and J. E. Paullin, M.D., Atlanta, Georgia; "Hospital Insurance and How to Make Use of It" by A. W. Adson, M.D., Rochester, Minnesota, and George Bussey, M.D., Chicago, Executive

(Continued on Page 1098)



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New York, N. Y.
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WAR BONDS AND STAMPS

(Continued from Page 1096)

Secretary American Hospital Association; and "The Public Comes First" by Herman L. Kretchmar, M.D. Chicago, and E. J. McCormick, M.D., Toledo. Date for these presentations have not as yet been set by The Council on Medical Service and Public Relations.

Dr. Foster also was appointed a member of the Special Committee on Health, Physical Education, Recreation, Camping, and Outdoor Education, of the Department of Public Instruction. This new educational project is designed to assist local schools in the improvement of their facilities and programs in healthful living

* * *

Ralph A. Perkins, M.D., of Detroit has been named Medical Director of the Westbury Chemical Company Inc. of New York.

AMA Fourteen-Point Program

"Doctors Point the Way" is the title of an excellent editorial published by Harry Myers in his *Lapeer County Press* of Lapeer, Michigan. He praises the American medical profession for announcing its 14-point program for expanding medical service based on extension of voluntary health insurance plans under local control:

"American medicine is fighting socialized medicine as a matter of principle, for it makes little difference to the fine doctors of our country whether or not our medical facilities become state controlled with everyone subjected to a compulsory tax for their support. The doctors who objected to being regimented by the state could quit.

"Doctors know that under socialized medicine in European countries, service to the public has not advanced as it has in the United States where ambition, enterprise and opportunity in medicine have carried its accomplishments beyond those obtained under any other system.

"First rumblings of what state medicine would mean to all the people have been heard in recent complaints about treatment and practices in the veterans' hospitals here at home. Such hospitals are not moved by the incentive to excel that governs independent medicine. The veterans' hospitals fall under political control, and the inevitable jealousies and prejudices that abound in bureaucratic organizations, creep in. They offer a good example of the pitfalls the public would encounter if our medical system were socialized and fell under political control.

"The fight to keep American medicine free in order to assure the extension of qualified public health and preventative medical service, is something the people should not make light of. Their future and not that of the doctors is at stake."

Good Reading

"The Carrier State of Poliomyelitis" is the title of an original article which appeared in JAMA of September 8 by the following authors: Thomas Francis, Jr., M.D., Harold E. Pearson, M.D., and Gordon C. Brown, Sc.D., of Ann Arbor.

(Continued on Page 1100)

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● A non-stilbene compound developed in the Research Laboratories of Schieffelin & Co., BENZESTROL enables the patient to make the climacteric transition smoothly, without the requirement of indefinite treatment.

Schieffelin BENZESTROL affords rapid alleviation of the symptoms of waning ovarian activity with a minimum of cost to the patient and with a low incidence of side reactions.

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Schieffelin BENZESTROL Vaginal Tablets

Potency of 0.5 mg.
Bottles of 100.

Literature and Sample on Request

(Continued from Page 1098)

L. J. Gariepy, M.D., Detroit, is author of an original article, "Acute Hemorrhagic Pancreatitis," which was published in *Western Journal of Surgery, Obstetrics and Gynecology*. Dr. Gariepy and J. H. Dempster, M.D., Detroit, are authors of "Clinical and Roentgenologic Diagnosis of Diaphragmatic Hernia" which appeared in the *Journal International College of Surgeons*, January-February, 1945.

* * *

"Your Doctor Speaks," a compilation of health messages carried in advertisements in national magazines sponsored by the Upjohn Company in its educational health campaign, has been forwarded to all members of the Michigan State Medical Society. Many physicians are placing this beautifully illustrated book in their reception rooms, available for patients to read.

* * *

"The Daily Pacifican," a newspaper published "somewhere on Luzon," Philippine Islands, contained a news story in August on the statement which the Michigan State Medical Society drafted requesting the immediate release of surplus medical officers from Military Service. The story also was reprinted in *Stars and Stripes*, and clippings were received by the State Society from England, Australia, Germany, India, et cetera.

* * *

Return Our Doctors

Newspaper editors generally throughout Michigan contributed valuable news space—and some wrote ex-

cellent editorials—on the statement of the Michigan State Medical Society relative to the release of unneeded medical officers from military service.

George A. Osborn in his *Sault Ste. Marie News* stated in his editorial, "Return Our Doctors:"

"The Michigan State Medical Society, recognizes the serious implications in a shortage of doctors, is making a determined effort to bring about the early separation from service of all medical men not needed in the armed forces. People generally will concur in the Society's insistent plea that immediate consideration should be given to the release of as many doctors of medicine as is consistent with the best interests of the armed forces and of the civilian population.

"As the Medical Society points out, doctors of medicine in military service have written a glorious chapter in the history of American medicine. In return, the Army should do as well by the medical profession."

Glenn MacDonald, Editor of the *Bay City Times*, in his "Release of Doctors" editorial, stated:

"Of course every doctor not needed for the care of men in military service should be released at once, as the Michigan State Medical Society is urging. The number now available for civilians is far below what it should be and public health is likely to suffer as a consequence. . . . The doctors are overworked."

(Continued on Page 1102)



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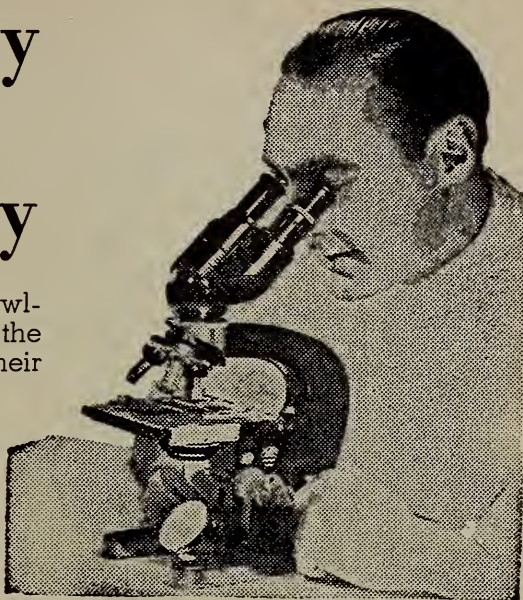
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(Continued from Page 1100)

J. E. Campbell of the *Owosso-Argus-Press* stated in his "Doctors Needed on Home Front":

"The plea of the Michigan State Medical Society to the federal government that surplus doctors should be released from the armed forces is well taken. There is hardly a community in the State, which is not suffering to some extent from the lack of enough medical service. . . . Civilian health has been good during the war despite the lessened medical attention possible. Two things have helped this situation. "One, the people have been living a saner life due to the pressure of their war responsibilities and the limitations through the influence of government restrictions. The other factor is that the doctors at home have been working beyond their strength in many cases to carry the medical load. As soon as doctors are no longer needed in their special fields in the service, they should be returned home."

Miscellaneous

* * *

MSMS Commercial Radio Program.—Since September 30, the MSMS commercial radio program over Station WJR (760 kilocycles), Detroit, has been heard at 5:30 p.m. CWT (not 6:30 p.m. EWT, as Detroit went back to slow time on October 1, 1945.)

Urge your members to listen to the MSMS program, every Friday, at 5:30 p.m. CWT.

Notice, Doctors: Please take advantage of the samples and literature offered by your advertisers. Some advertisers evaluate reader interest in medical journals by the number of coupons or requests received.

Seven advertisers in this issue of *THE JOURNAL* invite you to write for reference books, literature, or samples. Can you find them?

More important, will you co-operate?

* * *

Incidence of Illness.—It has been estimated that in a normal year, of every million persons

470,000 will not be sick

320,000 will be sick once

140,000 will be sick twice

50,000 will be sick three times

20,000 will be sick four times or more.

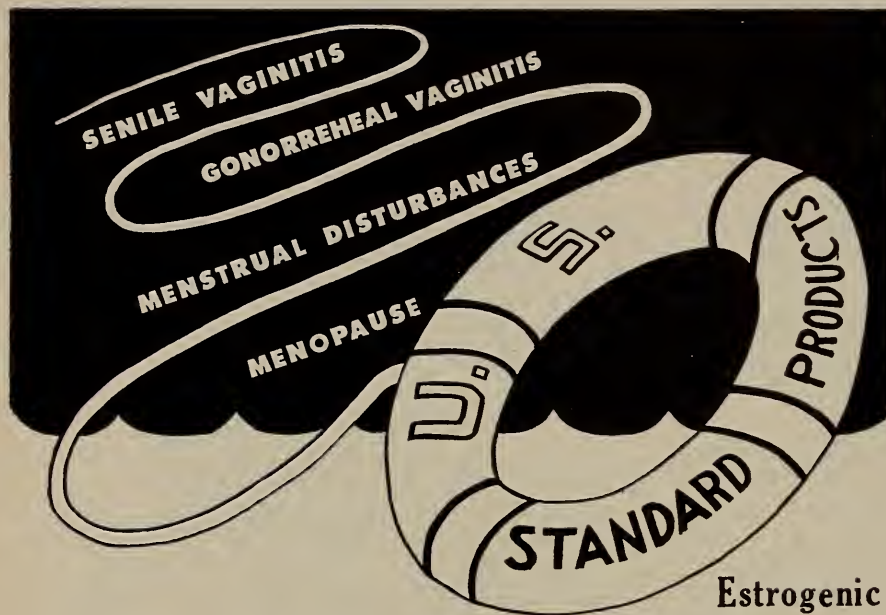
* * *

A total of \$16,589,874 was contributed to the 1945 March of Dimes of the National Foundation for Infantile Paralysis. This is approximately four and one-half million dollars more than was contributed in 1944.

* * *

"For every soldier killed in the armed forces, 17 people die in this country from preventable causes."—Oklahoma State Medical Association.

(Continued on Page 1104)



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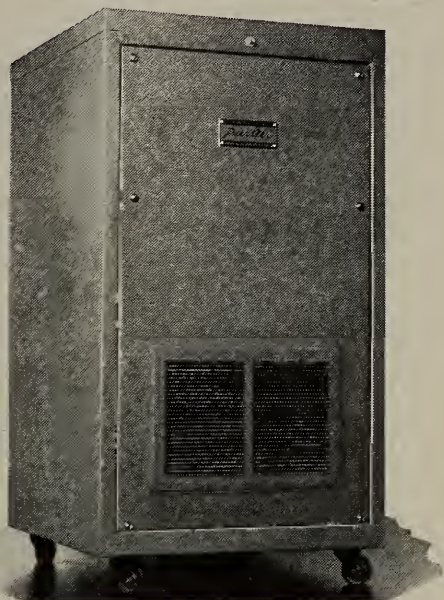
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(Continued from Page 1102)

Educational opportunities under the GI Bill of Rights are being seized by only 1.5% of discharged men, according to Col. Phillip C. Pack, Director of the State Office of Veterans' Affairs.

Colonel Pack felt that this low percentage is not due to lack of interest but to the inadequacy of the federal provisions which he felt should be augmented by the State of Michigan, to meet something near the actual cost of educational requirements.

Only 1,484 veterans, out of 97,062 discharged servicemen from this State, are receiving training under Public Law 16, according to figures to September 1, 1945.

Colonel Pack also indicated that many of the men discharged to date are older and either had definite occupations awaiting them or are over twenty-five years of age and do not come under the GI Bill provisions. He stated that approximately one-fourth of the men released have been re-employed in their pre-war jobs.

* * *

Annual Dues \$100

For the following reasons the 1945-46 dues of the California Medical Association will be \$100:

"(a) Loss of revenues in the past three years, due to waiver of dues of members in the armed services, now numbering over 2,200.

"(b) Need for adequate funds to aid doctors returning from the armed services and, in general, to assist during the inevitable disruption of relocation from war-time peacetime practice.

"(c) Need for adequate funds for postgraduate studies and refresher courses for doctors whose practices have been restricted, due to military service or work in war industrial areas.

"(d) Need for further funds to promote more widespread participation in voluntary medical and hospital prepayment plans; and

"(e) Necessity of re-establishing the reserves of the association, which are being constantly diminished by costly national and state public relations activities and increased cost of operation of all association functions."

The California Association has 4,000 home-front members.

* * *

Age of Physicians in Practice

Sixty-five per cent of the physicians in practice today in Pennsylvania, outside of Allegheny and Philadelphia counties are more than 56 years of age, twenty-five per cent being over sixty-five years old.

* * *

The patient population of Army hospitals reached an all-time high with 312,000 listed on the 14th of August.

"When it is considered that the average period of hospitalization of our battle casualties is about five and a half months after they arrive in a United States hospital, it can readily be seen that the work of the Army Medical Department does not stop with the cessation of hostilities."—GENERAL NORMAN T. KIRK.

* * *

Prescriptions Not to Be Refilled

The 1945 Legislature of Michigan adopted Senate Enrolled Act No. 66 limiting the refilling of Prescriptions

(Continued on Page 1106)

Quality carries on



C All worth while laboratory examinations; including—

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\$50.00 weekly indemnity, accident and sickness	Quarterly
\$15,000.00 accidental death	\$24.00
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86¢ out of each \$1.00 gross income used for members' benefit

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PAID FOR CLAIMS

\$200,000.00 deposited with State of Nebraska for protection of our members.
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43 years under the same management

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(Continued from Page 1104)



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except under certain conditions, and appointing the Michigan State Board of Pharmacy to prepare lists, to be published.

The following is the list of preparations authorized by the Michigan Board of Pharmacy under Enrolled Act 66 Public Acts of 1945, which permits refilling of prescriptions for the following items, *except* when the prescribing doctor indicates that such prescription cannot be refilled.

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Tedral Enteric Coated

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Kres-Lumin Syrup

Lumalgin Tablets

Lumodrin Tablets

Puraminal Elixir and Tablets

Theominal Tablets

E. R. Squibb & Sons

Ipral—Aspirin

Eli Lilly and Company

"Enseals" (Enteric-Sealed Tablets, Lilly)

Amesec Pulvules Amesec

"Enseals" Ephedrine and "Seconal Sodium"

Pulvules Ephedrine and "Seconal Sodium"

Pulvules Aminophylline and "Amytal"

Pulvules "Amytal" and "A.S.A."

Pulvules Ephedrine and "Amytal"

Pulvules Epragen

Pulvules "Theamin" and "Amytal"

Tablet Ephedrine and "Amytal"

Tablet Phenobarbital and Belladonna

Lederle Laboratories

Tablets of Aminophylline

Tablets of Mannitol Hexanitrate

Paxonin Tablets

The Upjohn Company

Aminopyrine and Phenobarbital Compound, Compressed Tablets

Aminopyrine and Phenobarbital Compound, Elixir

Ephedrate, Compressed Tablets

Ephedrine and Cyclogal Capsules

Phenobarbital and Belladonna Tablets

Phenobarbital and Belladonna, No. 2, Tablets

Theobromine-Phenobarbital Compound, Compressed Tablets

Theobromine-Phenobarbital (Plain), Compressed Tablets

(Continued on Page 1108)

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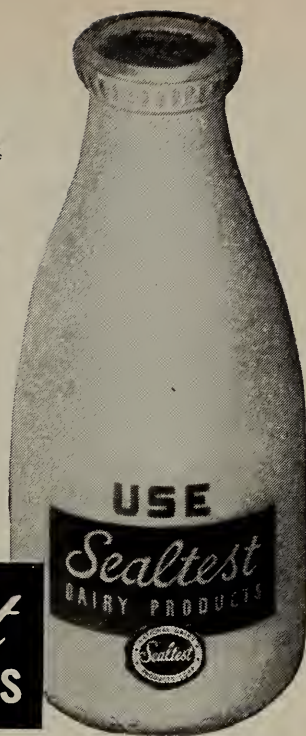
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(Continued from Page 1106)

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Aminophyllin 3 gr. with Phenobarbital ¼ gr.
Aminophyllin 3 gr. with Phenobarbital ½ gr. Enteric Coated
Aminophyllin 2½ gr. with Potassium Iodide 2 gr. and Phenobarbital ¼ gr.
Amodrine plain (containing Phenobarbital ⅛ gr.)
Amodrine enteric coated (containing Phenobarbital ⅛ gr.)
Pavatrine 2 gr. with Phenobarbital ¼ gr.

Abbott Laboratories

Amino-Neonal Tablets
Calcidrine Syrup
Calcidrine Syrup with Codeine
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Ephedrine and Neonal Tablets
Ephetal Tablets
Glucophylline and Nembutal Tablets
Glucophylline and Nembutal No. 2 Tablets
Manartal Tablets
Nembu-Fedrin Capsules
Nembutal and Belladonna Capsules
Nembutal and Aspirin Capsules
Neonal and Aminophylline Tablets
Neonal and Aspirin Capsules
Neonal with Phenacetin Tablets
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Citation for Legion of Merit

Henry R. Carstens, 0162798, Colonel, Medical Corps, 17th General Hospital, for exceptionally meritorious conduct in the performance of outstanding services in Italy from 28 October, 1944, to 8 May, 1945. Displaying high qualities of leadership, executive ability and keen foresight, Colonel Carstens, as Commanding officer of the 17th General Hospital, directed and co-ordinated the activities of the hospital during several trying periods so that it functioned as a smooth running organization, providing superior medical and surgical care to the wounded and sick. By setting an example of initiative and enthusiasm, with complete disregard of personal comfort and length of working hours, he inspired the officers and enlisted men under his command to a similar attitude and was thus instrumental in maintaining a continuous high state of morale that was a tribute to the superior services rendered by the 17th General Hospital and the Medical Department of the Army of the United States. Entered Service from Detroit, Michigan.

With the war now over, such replacements as are still needed for the armed services can well come from inductees not qualified to prepare for medical and scientific careers, and men on duty who should undertake such studies ought to be returned at the earliest moment.—
PAUL V. McNUTT.

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PHYSICIAN SUPPLY INADEQUATE

(Continued from Page 1022)

more prolonged deficiency in medical school teachers and investigators in the basic sciences.

"The recent policies of the national authorities pertaining to pre-medical students will more than offset the net gain (5,127 in the next few years).

"The relative numbers of medical students in medical schools during the year 1944-1945 and the influence of the military is shown by this table:

	Army	Navy	IV-F	Occup. Defer.	Veterans	Under 18	Other Men	Women	Total
Freshmen	1,125	1,889	347	1,706	558	29	399	470	6,523
Sophomores	2,725	2,170	200	384	40	..	120	340	5,979
Juniors	3,843	1,320	122	84	21	1	41	268	5,700
Seniors	3,999	1,321	69	77	15	..	71	274	5,826
Totals	11,692	6,700	738	2,251	634	30	631	1,352	24,028

"In 1946 the medical schools must obtain their students from the group which supplied only about one-fourth of the 1944-1945 class. This table shows a marked increase of women students, but records show women graduates have not materially changed during the past ten years: 282, 261, 252, 285, 273, 310, 305, 271, 267, 282, 279 (This includes the second graduation of 1944)."

The aspirations of man are surely unlimited and unpredictable—at least in the State of Colorado. It appears that there has been introduced into the legislature of that commonwealth a bill, S. 457, which "proposes to authorize licensed chiropractors to execute death certificates."

One pauses for a moment of reflection after reading that one! One realizes that it is well for anyone to be prepared for any emergency amid the manifold uncer-

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tainties of this life, but are we in error, or does the execution of a death certificate in Colorado require a diagnosis of the cause of death?—*New York State J. Med.*, Oct. 1, 1945.

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OBSTETRICS—Two-Week Intensive Course, October 8.

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

THE PHYSIOLOGY OF THE NEWBORN INFANT. By Clement A. Smith, M.D., Professor of Pediatrics, Wayne University College of Medicine; Medical Director, The Children's Hospital of Michigan. Springfield, Illinois: Charles C. Thomas, 1945. Price, \$5.50.

So far as we know, this book is unique. Its field has been covered sketchily and at long intervals. Studies of physiology *in utero* and in the newborn are a new field and are especially interesting. Their significance for adult life is manifest. Methods of investigation are given and authorities on physiological subjects are quoted. The chapters on neonatal respiration, intrauterine respiratory movements, and blood gas chemistry are all inclusive. Studies are given of the blood structure, erythrocytes, blood coagulation, and icterus neonatorum. Metabolism gets full consideration, including heat regulation and body temperature. Chapters discuss the digestive tract, nutrition, assimilation and metabolism of the specific food substances, renal function and the sex hormones. There is also a chapter on neonatal immunology. This book is most interesting and full of inspiration.

A MANUAL OF SURGICAL ANATOMY. Prepared under the Auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council, by Tom Jones and W. C. Shepard. 195 pages with 267 illustrations on 138 figures, 153 in colors. Philadelphia and London: W. B. Saunders Company, 1945. Price \$5.00.

Drs. Jones and Shepard have produced a volume of one hundred-thirty-nine pages of beautifully executed drawings in color illustrating every part of the human surgical anatomy. The pictures are large, minutely marked, every nerve, bone, muscle, blood vessel being indicated. This is one of the Military Surgical Manuals produced under the auspices of the National Research Council, and is a beautiful example of the bookmakers art. There is no text, but there are fifty-five pages of "explanatory index." As its name indicates this is a manual of Surgical Anatomy, and a satisfactory atlas to review just before starting some unusual surgical procedure. It is a source of the kind of information the surgeon must always have at his finger tips.

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NOTES ON COURT DECISIONS, STATUTES AND OTHER AUTHORITIES

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MEDICAL ADVICE BY RADIO

Although there is little judicial authority on the subject of the practice of medicine through radio broadcasting, the one case which came before an appellate court is of interest. The effect of this one decision has been so far reaching that it is doubtful whether further attempts will be made to diagnose human ailments or prescribe treatment by radio.

The late "Doctor" J. R. Brinkley established at Milford, Kansas a radio station, known by the call-letters KFKB. The station was first licensed by the Secretary of Commerce in 1923. In 1930 an application for renewal of license was denied by the Federal Radio Commission on the ground that the public interest, convenience or necessity would not be served by the station. From this determination an appeal was taken to the Court of Appeals of the District of Columbia.

The evidence showed that Brinkley conducted daily broadcasts on this station, which he called "The Medical Question Box." The program was devoted to diagnosing and prescribing treatment of cases from symptoms given in letters addressed either to Brinkley or to the station. The patients were not known to Brinkley except by means of the letters, each letter containing a code signature which was used in making answers through the broadcasting station. The "Doctor" usually advised that the writer of the letter was suffering from a certain ailment and recommended the purchase from The Brinkley Pharmaceutical Association of one or more of Dr. Brinkley's prescriptions designated by numbers. In one of his broadcasts, presumably representative of all, Brinkley prescribed for forty-four different patients, advising all but ten, to procure from one to four of his own prescriptions. The following two broadcasts were typical:

"Here's one from Tillie. She says she had an operation, had some trouble 10 years ago. I think the operation was unnecessary, and it isn't very good sense to have an ovary removed with the expectation of motherhood resulting therefrom. My advice to you is to use Women's Tonic No. 50, 67, and 61. This combination will

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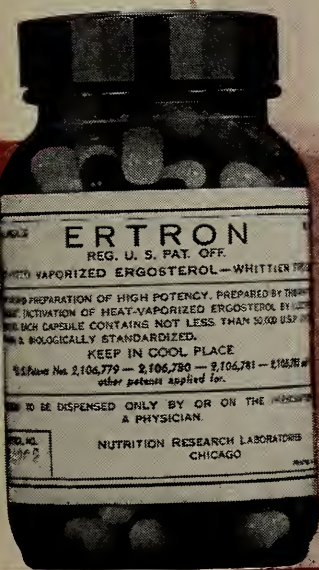
"Sunflower State, from Dresden, Kans. Probably he has gall stones. No, I don't mean that, I mean kidney stones. My advice to you is to put him on Prescription No. 80 and 50 for men, also 64. I think that he will be a whole lot better. Also drink a lot of water."

The Federal Radio Commission further found, "that the practice of a physician's prescribing treatment for a patient whom he has never seen, and bases his diagnosis upon what symptoms may be recited by the patient in a letter addressed to him is inimical to the public health and safety, and for that reason is not in the public interest. * * * The testimony in this case shows conclusively that the operation of Station KFKB is conducted only in the personal interest of Dr. John R. Brinkley. While it is to be expected that a licensee of a radio broadcasting station will receive some remuneration for serving the public with radio programs, at the same time the interest of the listening public is paramount, and may not be subordinated to the interests of the station licensee."

After holding that the business of broadcasting is a species of interstate commerce and subject to reasonable regulation of Congress, the Court of Appeals said, "In considering an application for a renewal of the license, an important consideration is the past conduct of the applicant, for 'by their fruits ye shall know them.' Matt. 7:20. Especially is this true in a case like the present, where the evidence clearly justifies the conclusion that the future conduct of the station will not differ from the past. * * * We are further of the view that there is substantial evidence in support of the finding of the Commission that 'medical question box' as conducted by Dr. Brinkley 'is inimical to the public health and safety, and for that reason is not in the public interest.' Appellant contends that the attitude of the commission amounts to a censorship of

(Continued on Page 1269)

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The 1945 MSMS House of Delegates continued the 1946 dues at \$12.00 but levied a per capita assessment for the ensuing year of \$25.00 for various purposes, including a public relations and public information program. The background and the critical need for the funds accruing from this assessment were supplied in an explanatory letter sent to all MSMS Delegates and County Society Presidents and Secretaries who were requested to convey this important information to the membership.

In a word, the funds will permit the Michigan medical profession to carry on a necessary public educational campaign aimed to prove that the best medical care for all the people is available only through voluntary methods. Thus, the facts about medical service, its distribution and costs, and the benefits to the people of the private practice of medicine, aided by supplementary facilities (such as Michigan Medical Service), will be told the public as never before.

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LET'S KEEP AMERICAN MEDICINE THE GREATEST IN THE WORLD

The final recommendation in the Annual Report of The Council, presented to and adopted by the 1945 MSMS House of Delegates, stated:

"The Council recommends that every individual Doctor of Medicine in Michigan strongly oppose all attempts leading to a complete compulsory sickness insurance program organized and maintained by government (as proposed in the Wagner-Murray-Dingell Bill of 1945); that they fight in a *positive way* to defeat such schemes by (a) eliminating any flaws that may result in complaints on the part of patients; (b) encouraging Michigan Medical Service, the voluntary program sponsored and operated by the Michigan medical profession itself—the greatest and most successful group medical care plan in the world; (c) by working with patients and the people generally, especially those in political office, to explain the benefits of a present system based on the time-tried private practice of medicine and the preservation of the physician-patient relationship which has made American Medicine the greatest in the world. Let's keep it that way!"

UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES

The Special Committee of the Michigan State Medical Society appointed to develop this fee schedule met early in September and reviewed 25,000 items in 121 individual fee schedules submitted by county medical societies, hospital staffs, and specialty societies of the state. The Special Committee arrived at a Uniform Fee Schedule for Governmental Agencies which it felt was fair to all parties concerned: first, to the patient; second, to the doctor of medicine who renders the service or commodity; and third, to the officials responsible for providing medical care to wards of government and to indigents.

The Special Committee's report was reviewed in detail and approved by The Council, which offered the following recommendation to the MSMS House of Delegates on September 17:

The Council recommends that the House of Delegates adopt the Uniform Fee Schedule for Governmental Agencies, subject to its final approval by the Special Committee which shall review and adjust any controversial items within the next thirty days; and that the House of Delegates authorize The Council to declare the Uniform Fee Schedule for Governmental Agencies in effect and operative upon receipt and approval by The Council of the final report of the Special Committee.

The House of Delegates of the Michigan State Medical Society, at its Annual Session of September 17-18, adopted the following resolution:

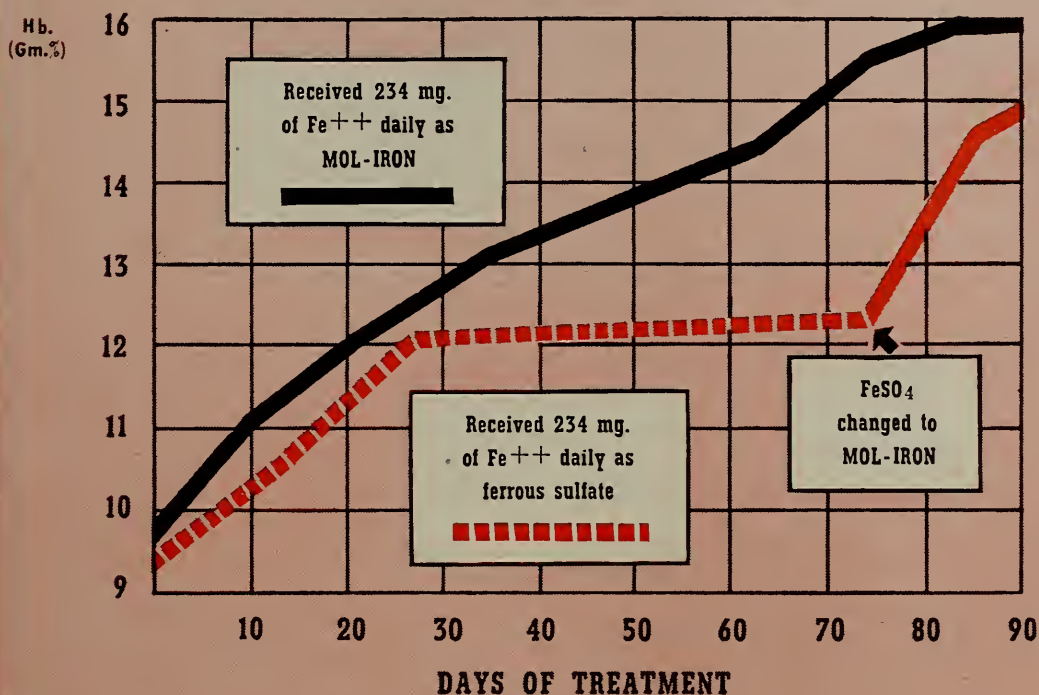
RESOLVED, That hereafter the minimal fee for medical care of wards of government and indigents shall be commensurate with the work done, and be it further

RESOLVED, That the fees in the Uniform Fee Schedule for Governmental Agencies, as developed by the Michigan State Medical Society, be considered the minimal fees for the service named, subject to revision in unusual cases—such unusual cases to be reviewed by a special board of doctors of medicine appointed by the Michigan State Medical Society, and be it further

RESOLVED, That the Uniform Fee Schedule for Governmental Agencies of the Michigan State Medical Society be herewith adopted, subject to final approval by the Committee appointed by The Council which shall review and adjust any controversial items within the next thirty days; and be it further

(Continued on Page 1132)

TYPICAL HEMOGLOBIN RESPONSE TO MOL-IRON AND TO FERROUS SULFATE IN PREGNANT WOMEN WITH IRON-DEFICIENCY ANEMIAS



The therapeutically superior effect of Mol-Iron in human beings is well demonstrated in the accompanying graph which illustrates the rate of hemoglobin regeneration in females during the last half of pregnancy and having approximately the same degree of iron-deficiency anemia. Results in this series of cases are typical of those observed in an evaluation* of Mol-Iron in a series of pregnant women with hypochromic anemia.

May we suggest that you make a comparable evaluation of Mol-Iron with your presently preferred therapeutic iron compound.

DOSAGE: One to two tablets three times daily after meals.

SUPPLIED: in bottles of 100.

*Neary, E. R., Preliminary Evaluation of Molybdenum-Iron Complex in Hypochromic Anemias of Pregnancy, to be published.

PHARMACEUTICAL

White
LABORATORIES, INC.
NEWARK 2, N. J.

MANUFACTURERS

UNIFORM FEE SCHEDULE

(Continued from Page 1128)

RESOLVED, That the Council of the Michigan State Medical Society is hereby authorized to declare the Uniform Fee Schedule for Governmental Agencies in effect and operative upon receipt and approval of the final report of the Committee appointed by the Council; and be it further

RESOLVED, That the members of the Michigan medical profession stand united behind the Uniform Fee Schedule for Governmental Agencies, as developed and adopted by the Michigan State Medical Society, and be it finally, and be it further

RESOLVED, That county and district medical societies immediately notify the various governmental agencies with whom they are in contact that the fee schedules of the Michigan State Medical Society will henceforth be in force as the minimum fee schedule for the care of governmental wards and for indigents, so that the medical profession may not be penalized by being forced to perform services at a financial loss.

Copies of the proposed uniform fee schedule for governmental agencies were sent to all county medical society secretaries early in October, with the request that any controversial items be forwarded to the Special Committee for review. The Special Committee held its meeting on October 17 to adjust any items not in complete accord. Its final report was presented to and approved by the Executive Committee of The Council at its October 18 session which, upon authority of the House of Delegates, declared the Uniform Fee Schedule for Governmental Agencies in effect and operative as of January 1, 1946.

Copies of the Schedule are being mailed to all MSMS members.

CONTINUATION COURSES FOR MEDICAL VETERANS

The Michigan State Medical Society has been working for several months to arrange a variety of continuation courses in an attempt to meet the needs of returning medical veterans of Michigan. This activity has been a co-operative one with the University of Michigan School of Medicine, Wayne University College of Medicine, and Wm. J. Seymour Hospital at Eloise.

The following courses have been developed:

University of Michigan, Ann Arbor, Michigan

- I. *Hospital Training* for Residents and Instructors—(a graduate program of prolonged duration leading to advanced degrees).

- II. *Intensive Review* course of two, four and six months' duration (this includes basic sciences, internal medicine, general practice review).
- III. *Brief special* review courses—three- to five-day duration from March through June. These courses cover some ten different subjects and can be taken separately or consecutively.
- IV. *Half day clinical* exercises for practitioners. These are repeated from September to June and are of a clinical nature.

Wayne University, Detroit, Michigan

- I. *The Graduate Curriculum*. This is a residency program in hospitals; leads to advanced degree and prepares for the American Specialty Boards. It is a course covering two to four years—according to the specialty chosen.
- II. *The Continuation Curriculum*. This is a refresher arrangement and embodies a review of the basic sciences. It leads to no degree but can be used in the fulfillment of some specialty board requirements.
- III. *Short Intensive Refresher Courses* of from one to three weeks. These will be largely clinical.

The following courses are in process of completion:

Wm. J. Seymour Hospital, Eloise, Michigan

- I. *Refresher courses for practitioners*.
(a) Continues for two, four or six weeks.
(b) Weekly—one afternoon and evening each week for thirty-six weeks.
- II. *Resident Training*. Some seventeen additional residencies will be provided. These will be for from two to four years and will be in the specialty category (medicine, surgery, urology, neurology and psychiatry).

For further information regarding any of the above courses, military members of the Michigan State Medical Society are invited to address the Medical Veterans' Readjustment Program Committee, 2020 Olds Tower, Lansing 8, Michigan.

"FOR BETTER HEALTH"

The *Detroit News* of September 24, 1945, published a courageous and informative editorial under the title "For Better Health." Permission to print this excellent editorial in THE JOURNAL of the Michigan State Medical Society has been graciously granted by W. E. Scripps, President of the *Detroit News*:

"There are more than 800,000 people enrolled in the Michigan Medical Service on a prepayment plan which insures them the best medical care which science can provide, at low cost, regardless of the seriousness of the sickness.

"Obviously, that many people could not be
(Continued on Page 1134)



THIRD IN A SERIES OF CHALLENGES TO MEDICINE'S

Achievements For Tomorrow

TUBERCULOSIS, an ancient enemy of mankind, stood sixth in causes of death in 1942.* Continuous research, improved standards of living, and the application of new methods of treatment have reduced tuberculosis in the ranks of killers from first place at the turn of the century.

Until an effective vaccine or serum is discovered people must be educated to recognize the symptoms of tuberculosis and to consult a physician before the disease has made much progress.

To aid in such educational work we have prepared a pamphlet entitled "Watch Your Health". In it are simply-stated facts about this and other serious diseases. Copies for distribution to your patients are available on request.

* U. S. Summary of Vital Statistics, 1942.

WARREN-TEED

Medicaments of Exacting Quality Since 1920

THE WARREN-TEED PRODUCTS COMPANY, COLUMBUS 8, OHIO



Warren-Teed Ethical Pharmaceuticals: capsules, elixirs, ointments, sterilized solutions, syrups, tablets. Write for literature.



FOR BETTER HEALTH*(Continued from Page 1132)*

fooled into paying for something that is not good for them, or that does not 'fill the bill.' They can have the doctor of their choice. They are treated the same as the wealthiest patients in the land.

"These 800,000 like the setup in Michigan Medical Service, founded in 1939 by the Michigan State Medical Society on a non-profit basis and managed entirely by the medical profession of Michigan.

"These facts challenge any kind of central, politically conceived and controlled medical care."

* * *

MICHIGAN MEDICAL SERVICE NOW ENROLLS GROUPS OF FIVE OR MORE

In response to urging of doctors throughout the state, Michigan Medical Service is undertaking a number of new activities designed to extend enrollment to more of Michigan's citizens.

One important development is the addition of medical care in the hospital to the present surgical care program. The first groups already have been enrolled in this broader program, and Michigan Medical Service will continue with enrollment until it has acquired a sufficient group so that sound experience with this type of service can be accumulated.

During the month of August alone, Michigan Medical Service enrolled 41,000 new subscribers for surgical care. Enrollment now totals over *875,000 persons—or one out of every six residents of Michigan.*

In less than six years Michigan Medical Service has paid a total of over \$12,000,000 to Michigan doctors for services rendered in approximately 250,000 cases. Michigan Hospital Service is showing a similar rapid growth, and now has approximately 1,300,000 subscribers. Michigan Hospital Service has paid \$22,930,173.79 to the hospitals for services provided in 493,739 cases.

Together the two Plans recently announced that enrollment requirements have been lowered so that employed groups of as few as five persons now may enroll. It is expected that this new provision will enable several thousand of Michigan's smaller employers to make the Service available to their employees for the first time.

UNIVERSITY OF MICHIGAN MEDICAL DEPARTMENT GRADUATION EXERCISES

A major factor in the Army's record of saving the lives of almost ninety-seven out of every hundred wounded men who reached a hospital was the quality of surgical care given these soldiers, Brigadier General Fred W. Rankin, Chief Consultant in Surgery of the Army Medical Department, told the graduating class of ASTP and V-12 students at the University of Michigan School of Medicine on September 15 at Ann Arbor, Michigan.

The lowered mortality rate in this war also was achieved because the highly qualified surgeons did their work without loss of time and also because hospital facilities staffed by specialists were placed near the front.

General Rankin said the average wounded man received his initial surgery at an evacuation hospital within ten hours of the time of his injury.

"In carefully selected cases," General Rankin added, "in which surgery was done at field hospitals the average time lapse was considerably less."

The efficient operation of the Army chain of evacuation made this possible. It starts at the time a man is wounded, and it is usually only a matter of a few minutes before the Medical Corpsman gives emergency treatment.

General Rankin explained that the Army's accomplishments were possible partly because of the method of assigning qualified specialists and also to the dissemination of information through the Consultants Division as to the best methods to be used under certain circumstances.

"The general principles of wound management were two-fold: initial debridement and delayed wound closure," the General continued. "The use of this method in the Mediterranean Theater of Operations resulted in primary healing in 95 per cent of the cases in which it was used and was attended with no loss of life or limb and with no serious complications."

Improved techniques reversed the ratio of deaths and survivals in abdominal injuries as compared with that of the last war. About sixty per cent of the casualties in the last war were fatal, while in this war sixty per cent of such casualties survived.

The so-called early nerve suture resulted in regeneration in eighty-five per cent of the cases in this war, according to the General. Another no-

(Continued on Page 1136)



Physicians everywhere are shifting to SODASCORBATE—*neutral* sodium ascorbate tablets—in the treatment of conditions in which vitamin C is indicated. In this way they are securing the maximum corrective effect without the acid-shift, gastric irritation and laxative action that too often result from massive doses of straight ascorbic acid.

SODASCORBATE truly marks a new milestone in vitamin C therapy, for it is the *only* product that supplies *neutral* sodium ascorbate for *oral* administration. With SODASCORBATE you can administer *full* and *frequent* doses of vitamin C without undesired after-effects. Each SODASCORBATE Tablet contains 120 mg. of sodium ascorbate, equivalent in vitamin C activity to 100 mg. (or 2000 U.S.P. units) of ascorbic acid.

SODASCORBATE Tablets are indicated in clinical and subclinical scurvy, and in all conditions where vitamin C has been found of value. Recent studies suggest its use in infectious diseases and toxic conditions; in pregnancy and lactation; in allergies, especially hay fever; in some cases of gingivitis and pyorrhea; for lack of energy and endurance associated with vita-

min C deficiency; and as a chlorine-free substitute for salt in heat-exhaustion.

THE AVERAGE DOSE for adults and children over 12 years is one tablet three times daily, or as indicated by the condition. For children under 12, one-half tablet. This may be dissolved in milk for babies and young children.

SUPPLIED IN BOTTLES of 40 and 100 tablets, as well as in "hospital-size" bottle containing 500 tablets. For professional samples and covering literature, sign and mail the coupon.

"New Horizons in Vitamin C Therapy"



This 32-page monograph contains much interesting and valuable information on vitamin C therapy. Brief, concise, authoritative. Most comprehensive bibliography. Mail the coupon for your copy.

VAN PATTEN PHARMACEUTICAL CO.
500 N. Dearborn Chicago 10 MSJ-11

Please send professional samples of SODASCORBATE Tablets and 32-page monograph "New Horizons in Vitamin C Therapy."

Dr. _____

Address _____

Town _____ State _____

MEDICAL DEPARTMENT GRADUATION EXERCISES

(Continued from Page 1134)

table accomplishment in this war has been the reduction in the mortality rate in the dangerous cases, or the head, chest and abdomen wounds, which is only half as high as during the last war.

Reconstructive and rehabilitative surgery designed to correct the disfiguring consequences of battle wounds is achieving results "that can fairly be termed miraculous," General Rankin said.

General Rankin, one of the outstanding surgeons in the country, and former president of the American Medical Association, awarded Army and Navy commissions to the ASTP and V-12 graduating members of the University of Michigan School of Medicine.

OHIO MEDICAL INDEMNITY SERVICE HIRES MICHIGAN MAN

Charles H. Coghlan, who has been Assistant Director of Michigan Medical Service, has been named Director of the Ohio Medical Indemnity Company in Columbus. Mr. Coghlan has been in Ohio since the middle of August, assisting in the organization of the Ohio medical plan. Announcement of his appointment as chief executive of the Ohio Medical Indemnity was made recently.

With Michigan Medical Service practically from its inception in 1940, Mr. Coghlan has been greatly responsible for its growth to where it is now protecting some 800,000 persons against surgical bills. He is widely known in Michigan medical circles.

The newly organized Ohio Medical Indemnity Company is patterned closely after the Michigan plan, which is the largest as well as one of the oldest surgical service plans in the country.

BOARD ACCEPTS GRANTS

The Board of Education at its last meeting authorized acceptance by the Wayne University College of Medicine of a grant of \$2,400 offered by the Jennie Grogan Mendelson Memorial Fund. The grant will be used to finance continuation of the research in multiple sclerosis conducted under the direction of Dr. Gabriel Steiner, associate professor of pathology at the College of Medicine.

Also accepted was the offer of the Committee on Therapeutic Research, Council on Pharmacy and Chemistry, American Medical Association, of the sum of \$375 to be used for an investigation of plasma constituents.

OLEOMARGARINE AND THE COUNCIL ON FOODS AND NUTRITION

Misinterpretation is being placed on the action of the Council on Foods and Nutrition in withdrawing acceptance from individual brands of oleomargarine. Reports published in the periodicals devoted to the interests of

the dairy industry and comment stimulated in the public press falsely attribute this action to a lack of confidence in the nutritional value of margarine. Such is not the case. The report of the Council on Foods and Nutrition in *THE JOURNAL*, Sept. 16, 1944, stated clearly that margarine is considered a general purpose food and therefore outside the Council's scope of acceptance, now limited to "special purpose" foods. For this reason acceptance is no longer granted to margarine. Confidence in the nutritional value of margarine fortified with vitamin A was reaffirmed by the Council at the time acceptance was withdrawn. The attempts of those opposing margarine to cast doubt and suspicion on its food value as a result of the withdrawal of acceptance by the Council are unwarranted and misleading.

WAYNE STARTS STUDY OF VIRUS DISEASES

Research on virus diseases will be initiated at the Wayne University College of Medicine this fall, following acceptance by the Board of Education of a grant of \$2,500 plus equipment from Dr. Hugo Freund and the Children's Fund of Michigan. Dr. Carl E. Duffy, assistant professor of bacteriology and clinical pathology, has been assigned to the project.

A grant of \$7,500 from Parke, Davis and Company for work in the field of blood substitutes and another of \$2,500 from Smith, Kline, and French Laboratories for research on the action of drugs on the nervous system also were accepted.

The blood substitutes research will be carried out under the direction of Dr. Walter H. Seegers, associate professor of physiology; that on the nervous system by Dr. Amedeo S. Marrazzi, professor of pharmacology and therapeutics.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States and Canada on Saturday, February 2, 1946, at 2:00 P.M. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year. All applications must be in the office of the Secretary by November 1, 1945.

All candidates are now required to be out of medical school eight years and in that time they must have completed an approved one-year internship and at least three years of approved special formal training, or its equivalent by the preceptorship method under a recognized obstetrician-gynecologist or a diplomate of this Board, in the seven years following the intern year. This Board's requirements for internships and special training are similar to those of the American Medical Association since the Board and the A.M.A. are at present co-operating in a survey of acceptable institutions.

All candidates are required to take the Part I examination which consists of a written examination and the submission of twenty-five case history abstracts, and the Part II examination which consists of an oral-clinical and pathology examination.

ASOCONSTRICTION
IN
MINUTES
ACTERIOSTASIS
FOR
HOURS

IN
SORE THROAT

So that Paredrine-Sulfathiazole suspension will remain on infected areas hour after hour, and thus maintain its maximum bacteriostatic action, the sore throat patient should be advised: (1) to instill the Suspension intranasally *after* eating and just before retiring; (2) to refrain from drinking fluids as long as possible after each instillation; and (3) to reduce nose-blowing and throat-clearing to a minimum. Smith, Kline & French Laboratories, Philadelphia, Pa.

A Z O L E S U S P E N S I O N

NOVEMBER, 1945

Say you saw it in the Journal of the Michigan State Medical Society

1139

\$33,000 Pledged to Michigan Foundation for Medical and Health Education

The Michigan Foundation for Medical and Health Education, sponsored by the Michigan State Medical Society, was incorporated on September 21, 1945, two days after the organization meeting of the incorporators in Detroit. The in-

additional \$11,000 was contributed to the Foundation during the month following Dr. Brunk's proposal. (Contributors listed, page 1142).

While many of the initial gifts were in cash, contributions to the Foundation through War



MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION
Incorporators' Meeting in Detroit, September 19, 1945

Front row—L. Fernald Foster, M.D., Bay City, A. S. Brunk, M.D., Detroit, E. I. Carr, M.D., Lansing, R. S. Morrish, M.D., Flint, E. F. Sladek, M.D., Traverse City, P. L. Ledwidge, M.D., Detroit, J. M. Robb, M.D., Detroit.

Middle row—F. H. Drummond, M.D., Kawkawlin, Wilfrid Haughey, M.D., Battle Creek, A. H. Miller, M.D., Gladstone, T. E. DeGurse, M.D., Marine City, E. R. Witwer, M.D., Detroit, A. B. Smith, M.D., Grand Rapids, W. E. Barstow, M.D., St. Louis, R. H. Stevens, M.D., Detroit.

Rear Row—D. W. Myers, M.D., Ann Arbor, C. E. Umphrey, M.D., Detroit, O. O. Beck, M.D., Birmingham, R. J. Hubbell, M.D., Kalamazoo, P. A. Riley, M.D., Jackson, B. R. Corbus, M.D., Grand Rapids, W. H. Huron, M.D., Iron Mountain.

Those absent when photograph was taken were: J. D. Bruce, M.D., Ann Arbor, Wm. A. Hyland, M.D., Grand Rapids, R. C. Pochert, M.D., Owosso, O. D. Stryker, M.D., Fremont.

corporators included the members of the MSMS Council, the Postgraduate Foundation Committee, and those elected to membership in the Foundation.

The purposes of the Foundation are:

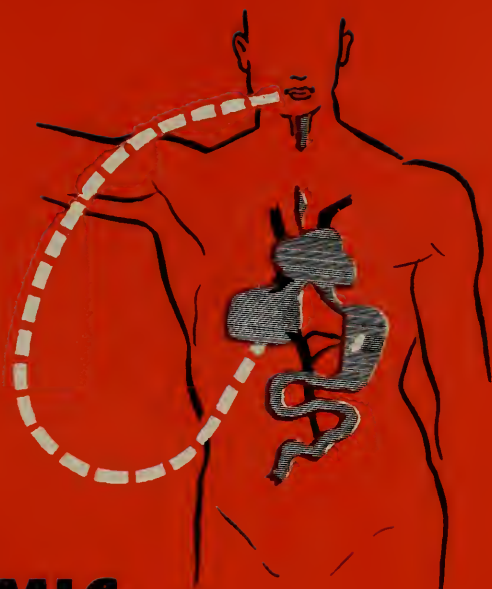
"To acquire, provide, use, develop, endow, and finance methods, means and facilities for post-graduate education in Medicine, for education in Medicine, for lay health education, and for research, fellowships and scholarships."

A. S. Brunk, M.D., Detroit, in his President's Annual Address to the MSMS House of Delegates, offered to contribute \$1,000 to the Foundation provided ninety-nine others—to be known as *The Founders*—would make a similar contribution during the next year. Within a few hours, \$19,000 was pledged by medical men who heard President Brunk's address on September 19. An

Bonds, pledges, memorials, life insurance, in wills, or similar ways will meet President Brunk's specifications. The first 100 contributors of \$1,000 each will be listed as the permanent Founders and will include laymen and organizations interested in contributing to the Foundation.

The proposed \$100,000.00 from the 100 Founders will be added to the original MSMS contribution (\$10,000) and that of the late Dr. and Mrs. A. P. Biddle (approximately \$40,000), now assets of the MSMS Foundation for Postgraduate Medical Education, a trusteeship created by the State Medical Society four years ago, which will be transferred to the new Michigan Foundation for Medical and Health Education. Thus the new fund has good prospects for a total of \$150,000

(Continued on Page 1142)



INTESTINAL ABSORPTION
Long route through portal system
to general circulation

ECONOMIC ANDROGENIC EFFECTS

PERLINGUAL ABSORPTION
Direct from sublingual vessels
to systemic circulation



WITH SMALLER DOSES

Metandren Linguets, especially designed for perlingual absorption, permit more complete utilization by side-tracking the liver where partial inactivation of methyltestosterone is known to take place. Dosage requirements are $\frac{1}{2}$ to $\frac{2}{3}$ those necessary to produce the same results when methyltestosterone is ingested.

METANDREN LINGUETS*

*Trade Mark Reg. U. S. Pat. Off. Ciba's trade name for waters of methyltestosterone.

CIBA PHARMACEUTICAL PRODUCTS, INC. • Summit, New Jersey

*a Ciba
Product*

\$33,000 Pledged

(Continued from Page 1140)

by September, 1946. The income will be available for postgraduate needs.

In order to effectuate the requirements of Dr. Brunk's offer, The Council was instructed by the House of Delegates to implement a plan for this purpose. The Council appointed each Delegate, each Councilor, each member of the Postgraduate Foundation Committee, and each President and Secretary of County Medical Societies in Michigan to a statewide Foundation Sponsoring Committee.

In these days of high income taxes, many contributors will welcome the opportunity to aid the Michigan Foundation for Medical and Health Education. It is anticipated that the Foundation Sponsoring Committee will exceed the goal of an additional \$100,000.00 for the Foundation during the next ten months. Judging from initial results, members of the Foundation Sponsoring Committee are viewing this project as a great opportunity to help build a permanent and beneficial monument to Michigan Medicine.

The first month's contributors were:

J. D. Bruce, M.D., Ann Arbor.....	\$1,000
A. S. Brunk, M.D., Detroit.....	1,000
Earl I. Carr, M.D., Lansing.....	1,000
C. V. Costello, M.D., Holland.....	1,000
H. H. Cummings, M.D., Ann Arbor..	1,000
E. H. Fletcher, Detroit.....	1,000
L. J. Hirschman, M.D., Detroit.....	1,000
Wm. A. Hyland, M.D., Grand Rapids.....	1,000
Joint Committee on Health Education, B. R. Corbus, M.D., Grand Rapids, Chairman.....	1,000
Francis Jones, M.D., Lansing.....	1,000
Harold L. Morris, M.D., Detroit.....	1,000
Lawrence Reynolds, M.D., Detroit.....	1,000
J. M. Robb, M.D., Detroit.....	1,000
G. B. Saltonstall, M.D., Charlevoix.....	1,000
Ralph Wadley, M.D., Lansing.....	1,000
John O. Wetzel, M.D., Lansing.....	1,000
E. R. Witwer, M.D., Detroit.....	1,000
Mrs. F. B. Miner, Flint, in memory of the late F. B. Miner, M.D.....	1,000
Michigan Medical Service.....	10,000
E. F. Sladek, M.D., Traverse City, has set aside in his will.....	5,000

Total in gifts and pledges from September 19 to October 15, 1945.....\$33,000

Name
Office Add..... City.....
Res. Add. City.....

I hereby pledge to the
MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION
2020 Olds Tower, Lansing 8, Michigan, for the twelve-month period
beginning September 19, 1945, the sum of

TOTAL PLEDGE	PAID HEREWITH	BALANCE DUE
\$	\$	\$

My contribution is

Please

Check

Your

Choice



- (1) In Cash ☐ to be paid in the total sum ☐
or in annual payments of \$.....
or (2) In War or Victory Bonds ☐ to be paid in the total sum ☐
or in annual payments of \$.....
or (3) In Life Insurance ☐
or (4) As a Memorial ☐ to the memory of:
.....
or (5) In my Will ☐

SIGNATURE



Red comfort

Serenium soothes inflamed genito-urinary hydrochloride) halts the growth of most membranes while possessing low toxicity bacterial urinary invaders. Administered and a wide margin of safety. Effective in orally, Serenium tablets ease the patient's either acid or alkaline urine, this red discomfort and constitute an effective dye (diamino-4'-ethoxy-azobenzene weapon against genito-urinary infections.

SQUIBB

Serenium

TRADEMARK

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858
 NOVEMBER, 1945

Say you saw it in the Journal of the Michigan State Medical Society

Michigan Rheumatic Fever Control Conference

The Michigan Rheumatic Fever Control Conference, sponsored by the Michigan State Medical Society and the Michigan Crippled Children Commission, chalked up "Another First For Michigan." The meeting at the Book-Cadillac Hotel, Detroit, on September 19 and 20 was attended by

Mass.; and John R. Paul, M.D., New Haven, Conn. Resident speakers were Moses Cooperstock, M.D., Marquette; John F. Holt, M.D., H. H. Riecker, M.D., and James L. Wilson, M.D., of Ann Arbor; Joseph A. Johnston, M.D., Gordon B. Myers, M.D., and Sol Rosenzweig, M.D.,



AT THE MICHIGAN RHEUMATIC FEVER CONTROL CONFERENCE
(Seated) Stanley Gibson, M.D., guest essayist from Chicago; and Carleton Dean, M.D.,
Lansing.
(Standing) Frank Van Schoick, M.D., Jackson, and L. Fernald Foster, M.D., Bay City.

249 registrants who gave high praise to the Committee on Rheumatic Fever Control of the State Society for the excellence of this extraordinary program and the smoothness of the physical arrangements.

R. S. Morrish, M.D., Flint, President of the Michigan State Medical Society, and Emmet Richards of Alpena, Chairman of the Michigan Crippled Children Commission, welcomed the audience to this first Michigan Conference on Rheumatic Fever.

Guest speakers were Stanley Gibson, M.D., Chicago; T. Duckett Jones, M.D., Cambridge,

of Detroit; Mark Osterlin, M.D., Traverse City; Charley J. Smyth, M.D., Eloise.

Presiding at the three meetings were L. Fernald Foster, M.D., Bay City, Frank Van Schoick, M.D., Jackson, and Carleton Dean, M.D., Lansing. H. H. Riecker, M.D., acted as able leader of the three round-table discussions.

Clinical demonstrations were presented on the final afternoon of the Conference at Wm. J. Seymour Hospital, Eloise, Children's Hospital, Detroit, and City of Detroit Receiving Hospital, Detroit.

(Continued on Page 1148)

in oropharyngeal infections

HIGH and PROLONGED salivary concentration of sulfathiazole is brought directly to the site of oral and pharyngeal infections following the use of—

White's SULFATHIAZOLE GUM*

Even a single tablet of White's Sulfathiazole Gum chewed for *one-half to one hour* provides a high concentration of locally active sulfathiazole. The medication is brought into immediate and *prolonged* contact with oropharyngeal areas which are not similarly reached by ordinary measures of topical chemotherapy. Moreover, resulting blood levels of the drug, even with maximal dosage, are so low that systemic toxic reactions are virtually obviated.

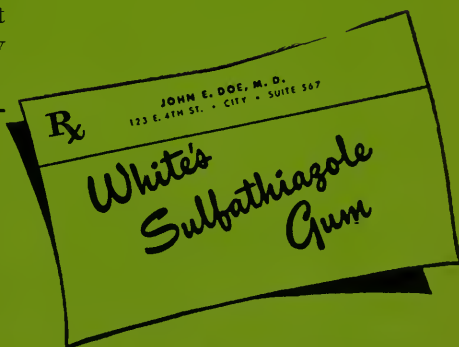
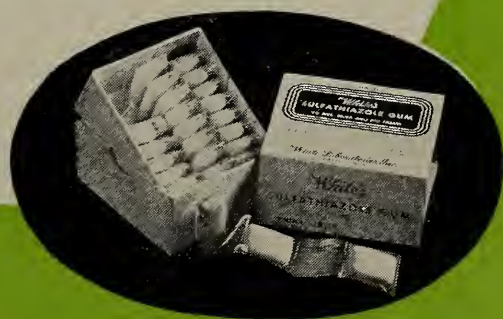
INDICATIONS: Local treatment of sulfonamide-susceptible infections of oropharyngeal areas:

- a. acute tonsillitis and pharyngitis;
- b. septic sore throat;
- c. infectious gingivitis and stomatitis;
- d. Vincent's disease

Also indicated in the prevention of local infection secondary to oral and pharyngeal surgery.

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IMPORTANT: Please note that your patient requires your prescription to obtain this product from the pharmacist.

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RHEUMATIC FEVER CONTROL CONFERENCE

(Continued from Page 1144)

Those registering at the Rheumatic Fever Control Conference included:

Alpena-Alcona-Presque Isle.—Emmet Richards, G. H. Wood, M.D., E. S. Parmenter, M.D.

Bay-Arenac-Gladwin-Iosco.—L. Fernald Foster, M.D., W. S. Gamble, M.D., Walter S. Stinson, M.D., R. C. Perkins, M.D.

Berrien.—John Lawther, M.D., Donald W. Thorup, M.D.

Calhoun.—Wilma Weeks Rorich, M.D., Bertha L. Selmon, M.D., Margery J. Gilfillan, M.D.

Clinton.—W. B. McWilliams, M.D.

Delta-Schoolcraft.—A. H. Miller, M.D.

Eaton.—G. C. Stucky, M.D.

Genesee.—John H. Charters, M.D., E. M. Eichhorn, M.D., John E. Wentworth, M.D., Arthur H. Johnson, M.D., Lafon Jones, M.D., Elwin E. Miller, M.D., M. S. Chambers, M.D.

Grand Traverse-Leelanau-Benzie.—Mark F. Osterlin, M.D., E. F. Sladek, M.D., B. B. Bushong, M.D., Harry L. Weitz, M.D., C. E. Lemen, M.D., Dwight Goodrich, M.D., Ellis J. Bolan, M.D.

Gratiot-Isabella-Clare.—Wm. L. Harrigan, M.D., W. E. Barstow, M.D.

Hillsdale.—G. F. Moench, M.D.

Ingham.—Carleton Dean, M.D., Margaret L. Towne, Elizabeth R. Vickins, Elizabeth Abram, Elizabeth K. Oher, Sue DeVries, R.N., Elizabeth Guillot, Kenneth J. Feeney, M.D., L. C. Towne, M.D., Floyd R. Town, M.D., George A. Sherman, M.D., Earl W. Brubaker, M.D., Robert H. Trimby, M.D.

Ionia-Montcalm.—M. G. Becker, M.D.

Jackson.—A. K. Payne, M.D., C. Corley, M.D., S. Lojacona, M.D., G. R. Bullen, M.D., Hilda A. Habenicht, M.D., J. D. Van Schoick, M.D., Frank Van Schoick, M.D.

Kalamazoo.—Frederick J. Margolis, M.D., Lolita Goodhue, M.D., Louis W. Gerstner, M.D., H. S. Heersma, M.D., Robert J. Armstrong, M.D.

Kent.—H. C. Robinson, M.D., C. G. Krupp, M.D., Clarice L. McDougall, M.D., I. G. DePree, M.D.

Lapeer.—K. W. McLeod, M.D.

Macomb.—M. M. Wilde, M.D., Harold Kessler, M.D.

Manistee.—Ward H. Norconk, M.D.

Marquette-Alger.—M. Cooperstock, M.D.

Monroe.—Florence Ames, M.D., L. H. Tomlinson, M.D., B. J. Fieldhouse, M.D.

Muskegon.—P. S. Wilson, M.D., M. E. Stone, M.D., D. R. Boyd, M.D., Robert A. Risk, M.D., W. M. LeFevre, M.D.

North Central Counties.—Gilbert B. Saltonstall, M.D.

Oakland.—Milton J. Uloth, M.D., W. G. Hutchinson, M.D., Campbell Harvey, M.D., O. R. MacKenzie, M.D., E. Kyle Simpson, M.D., Lee H. Halsted, M.D., Ethel T. Calhoun, M.D., C. R. Henry, M.D., H. A. Schuneman, M.D., C. T. Ekelund, M.D., Z. R. Aschenbrenner, M.D., L. A. Farnham, M.D.

Saginaw.—A. R. Moon, M.D.

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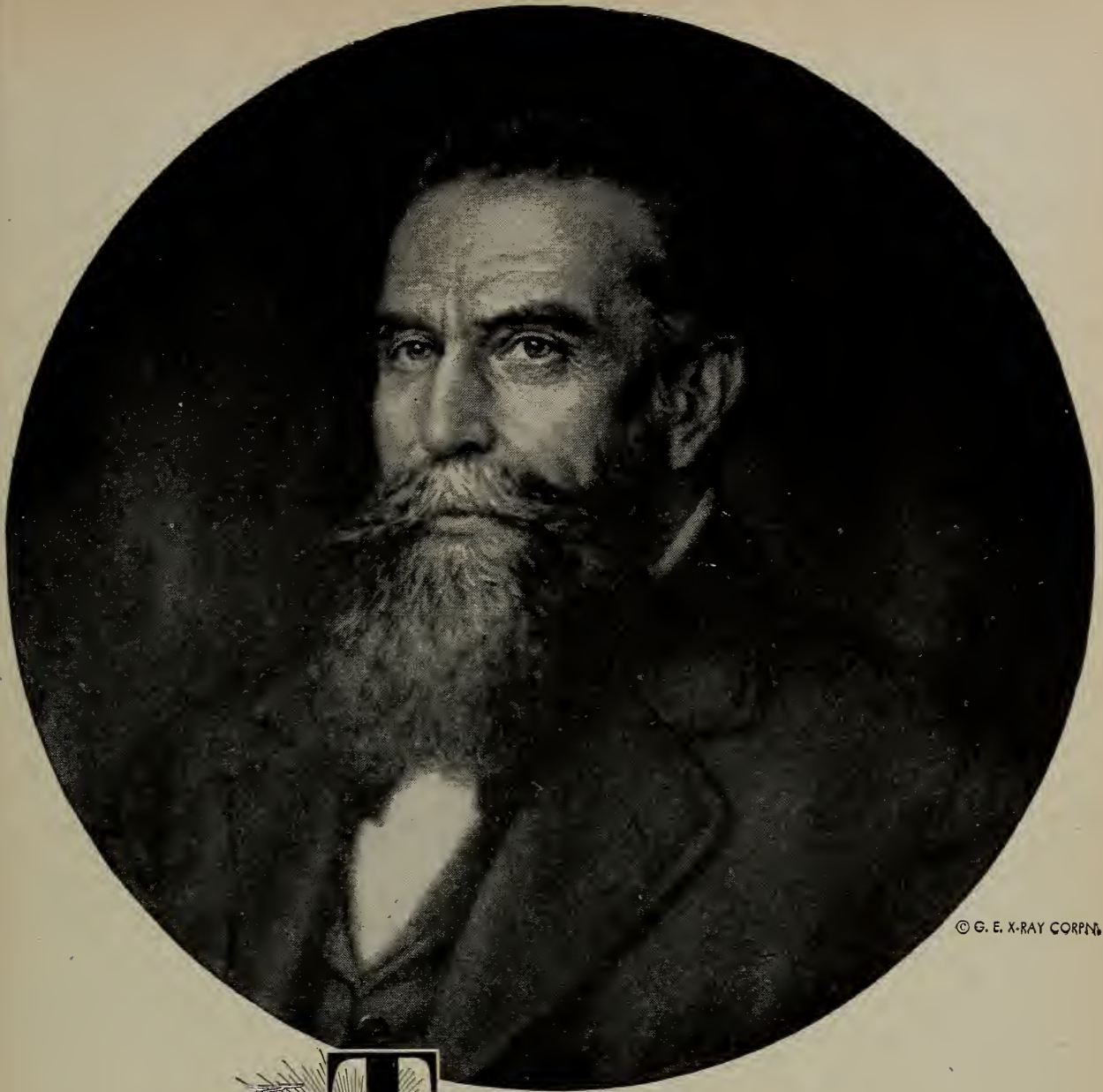
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Washtenaw.—John F. Holt, M.D., Mark Marshall, M.D., J. S. DeTar, M.D., James L. Wilson, M.D., Clark D. West, M.D., Leo A. Knoll, M.D., H. H. Riecker, M.D., George C. Finch, M.D., T. H. McEachern, M.D., D. E. Lichty, M.D., Albert F. Wilford, M.D., Donald W. Martin, M.D., Paul H. Bassow, M.D.

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Wexford.—W. J. Smith, M.D.

Guests—Patricia Bronté (Press), Herbert S. Wells, M.D., Edward F. Stegen, Chicago, Bernadette Banker, R.N., J. R. Paul, M.D., New Haven, Conn., T. Duckett Jones, M.D., Boston, Mass., Stanley Gibson, M.D., Chicago.




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OUR FIFTIETH YEAR OF SERVICE

GENERAL  ELECTRIC X-RAY CORPORATION

Medical Veterans' Readjustment

PROFESSIONAL TRAINING PLANNED FOR ARMY DOCTORS

In order to provide qualified doctors for the peacetime, Army plans have been formulated to interest Medical Corps officers who are serving for the duration of the war to apply for commission in the Regular Army, Major General Norman T. Kirk, Surgeon General of the Army, announced recently.

Among the more important attractions which will be offered Medical Corps officers who remain in the Army are the following:

1. The Regular Army Medical Corps officer will be assured a professional career offering broader possibilities in a larger field than the practice of the average civilian doctor affords.
2. The training and the assignments of Army doctors will be arranged to aid the Army doctors in obtaining board certification for specialties from the recognized civilian specialty boards.
3. Graduate training will be continued with the establishment of Army fellowships, residencies and special courses.

In addition to the above attractions, which carry decided weight with any professional man, the Army affords security in its pension system, hospitalization care and other considerations not usually available in civilian practice, whereas, civilian practice on the whole involves considerable uncertainty, and the locality in which a man has established himself and other factors seriously limit the scope of the practice a doctor can engage in, General Kirk said.

This program which is being inaugurated is designed to obtain and utilize to the best advantages the professional skill now available in the Army, according to Colonel Floyd L. Wergeland, Director of the Training Division of The Surgeon General's Office, and Chairman of the committee handling the professional training of Army doctors.

The plans under this policy call for the establishment of graduate training programs at Army Installations where the residencies will meet the requirements of specialty boards and arrangements will be made for accrediting by the appropriate specialty boards. Another phase of the program includes the establishment of Army internships at selected Army general hospitals.

Plans outline a procedure for giving professional rehabilitation and specialized training to Regular Army Medical Corps officers who have been in administrative work during the war. These doctors who have not been able to engage in practice because of administrative responsibilities will serve as understudies with doctors who have been active in professional practice. This assignment will lead to continued professional service and eventually specialty board certification.

The advantages of a professional career in the Army will also be brought to the attention of medical students to interest them in an Army commission. Only those

who stand scholastically in the upper third of their classes will be prevailed upon to consider the Army for a career.

HOSPITALS NAMED FOR REFRESHER TRAINING COURSES

On 10 September 1945 The Surgeon General notified the Commanding Officers of the following hospitals that their medical services had been approved for the professional refresher training of Medical Corps officers to extend over a twelve-weeks period:

Cushing General Hospital, Framingham, Massachusetts
Mason General Hospital, Brentwood, Long Island, New York
Valley Forge General Hospital, Phoenixville, Pennsylvania
Kennedy General Hospital, Memphis, Tennessee
Newton D. Baker General Hospital, Martinsburg, West Virginia
Percy Jones General Hospital, Fort Custer, Michigan
Winter General Hospital, Topeka, Kansas
McCloskey General Hospital, Temple, Texas
DeWitt General Hospital, Auburn, California

Medical Corps officers desiring refresher training in neuropsychiatry will be permitted to serve the entire twelve weeks on the neuropsychiatric services and to rotate through the various wards of the neuropsychiatric services in order to gain experience in all phases of neuropsychiatry.

The refresher course will follow Guide for Professional Refresher Training for Medical Corps Officers approved by SPTRU 353 (Med.) (13 Nov 44) dated 17 November 1944.

GRADUATE PROGRAM AND POSTGRADUATE CONTINUATION COURSES FOR VETERAN AND CIVILIAN PHYSICIANS

Wayne University College of Medicine

A very large proportion of the doctors who have been in military service desire the opportunity for some type of postgraduate training before returning to civilian practice. The older men feel the need of refresher courses to enable them to take up their specialties after having been restricted to the military type of practice. The younger men, often the product of the accelerated program of training, feel the need of more clinical work and the opportunity to prepare by further study for specialty board qualifications.

Wayne University College of Medicine offers graduate medical training in two categories:

- I. *The Graduate Curriculum* is based on the residency in hospitals affiliated with the College of Medicine for this type of training and leads to the degree of Master of Science in the appropriate specialty. In addition

(Continued on Page 1152)

INTERESTED IN CIGARETTE ADVERTISING?

Claims, words, clever advertising slogans do sell plenty of products. But obviously they do not change the product itself.

That PHILIP MORRIS are less irritating to the nose and throat is not merely a claim. It is the result of a manufacturing difference *proved** advantageous over and over again.

But why not make your *own* tests? Why not *try* PHILIP MORRIS on your patients who smoke, and *confirm* the effects for yourself.

* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

GRADUATE PROGRAM

Wayne University College of Medicine

(Continued from Page 1150)

to the major emphasis as exemplified by the residency, there is required a minor in one of the basic sciences which includes a period of actual laboratory work and research in addition to formal courses. The details of the program vary with each of the clinical specialties, the over-all program in each case being so designed that it more than satisfied the requirements of the appropriate specialty board.

The foregoing plan is in operation in general surgery, in internal medicine and in dermatology and syphilology where the program is completed in three years and in obstetrics and gynecology where four years are required to complete the work.

II. *The Continuation Curriculum* is designed as a series of correlated lectures, seminars, clinics and conferences. The aim is not only to satisfy the need of the practitioner for refresher courses but also to provide review of basic sciences and integrated work in the various specialties for residents in those Detroit hospitals whose residencies have been approved by the Council on Medical Education and Hospitals of the American Medical Association. Although the work carries no graduate credit, and leads to no graduate degree, it can be used in fulfillment of certain requirements of the specialty boards.

The following courses will be offered in this curriculum: General Endocrinology, Physiology of the Cerebrum, Experimental and Applied Nutrition, Biochemical Seminar, Advanced Histology, Regional Anatomy, Surgical Anatomy, Endocrinology of Reproduction, Immunology and Virology, Tropical Medicine and Parasitology, Dermatologic Pathology, Gynecologic Pathology, Hematology, Pathology of the Heart, Pediatric Pathology, Surgical Pathology, Medical Diagnostic Conference, Therapeutic Conference, Hematology Clinic, Electro-cardiography, Gastro-enterology, Surgery Conference, Survey of Pharmacology, Review of Physiology, Review of Physiological Chemistry, Principles of Therapeutics, and Physical Medicine. The curricular pattern will be repeated at relatively short intervals so as to fit in with the necessarily irregular program of the residents in the approval hospitals.

Plans are being laid for unit refresher courses, i.e., relatively short, intensive sessions of one to three weeks' duration, centering around the clinic but with the collaboration of the appropriate basic science faculty. Among other fields of specialization this plan would be offered in Cardiology, Ophthalmology, Proctology, Infectious Diseases, Pediatrics, Surgery of the Chest, Gynecology and Dermatology.

The schedule of arrangements with respect to classes and registration will be announced later. For further information consult Dr. Arthur H. Smith, Wayne University College of Medicine, Detroit 26, Michigan.

Eloise Hospital, Eloise, Michigan

Proposed Courses

The primary aim of the postgraduate program is to use the large amount of clinical material available at the institution for educational purposes.

The teaching program is to be constructed about the patient and the graduate student in a manner that will be co-ordinated with the existing and proposed programs of the Medical Department, University of Michigan, and Wayne University Medical School.

The general plan of teaching will be the assignment of a group of patients illustrating various phases of and related types of disease, and the holding of a "round-table" type of discussion concerning the cases studied. Emphasis will be placed on the application of the fundamental medical sciences, as applied to diagnosis and therapy. Medical and surgical aspects of disease entities will be treated concurrently whenever possible. The pure lecture type of instruction will be kept at an irreducible minimum and used only in emergency.

Types of Courses

A. Refresher Courses for Practitioners

1. Continuous 2- 4- and 6 weeks. (Enrollment limited to 20.)
2. Weekly—one afternoon and evening, weekly for 36 weeks. (Enrollment limited to 30.)

Types 1 and 2 will cover the same subject matter and will deal primarily with general medical, surgical, neurological and psychiatric subjects of interest to the general practitioner.

B. Resident Training

It is contemplated that the present Resident Training Program will be expanded to accommodate approximately twice the number of residents now at Eloise (17). Preference will be given to applicants in the following order:

1. Discharged members of the Armed Services whose training at Eloise was interrupted.
2. Discharged members of the Armed Services from Wayne County.
3. Discharged members of the Armed Services from the State of Michigan.
4. Others.

This program will be sufficiently extended so that the individual may be eligible for specialty board examinations in medicine, surgery, urology, neurology and psychiatry.

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FROM TOO MUCH SCRUBBING?**

Soften dry skin with AR-EX CHAP CREAM! Contains carbonyl diamide, shown in hospital test to make skin softer, smoother, and even whiter! Archives of Derm. and S., July, 1943. FREE SAMPLE.



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Undulant Fever Vaccine

(Abortus and Suis) (Bio. No. 62)

Brucella abortus . . . 1000 million per cc.

Brucella suis . . . 1000 million per cc.

Both available in 6 cc. and 20 cc. vials.

Selection of type of vaccine depends upon the history of the case.

Full literature on request.

"FIFTEEN years ago observed as a curiosity," Brucellosis is estimated as existing in "ten to fifteen per cent of the American population" . . . but unfortunately only "one per cent or less of infected cases reach detection and treatment."*

Whatever the source of infection—be it bovine, porcine, or other animal origin—Pitman-Moore Biological Laboratories offer a vaccine to meet your therapeutic requirements.

*Staub, R. R.: Brucellosis, An Unrecognized Menace, Northwest Med., 43:274-479 (Oct.), 1944.

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War Medicine

SUPPLY SERVICE ROLE IN MEDICAL DEPARTMENT ACHIEVEMENTS

The outstanding record of the Army Medical Department in this war and the role played by its Supply Service were discussed by Major General Norman T. Kirk, Surgeon General of the Army, at a recent conference of Medical Depot commanding officers and medical supply officers at Louisville, Kentucky.

"In May and June of 1943," General Kirk said, "centralization of stock control and storage operations in depots became evident. Plans were developed that would enable the Chief of the Supply Service to measure the work which was being performed in the Medical Department Depot system. This plan was placed into operation during the first few months of 1944, and has been extremely effective in the control of manpower, workload and getting supplies where they are needed when they are needed."

General Kirk pointed out that as a result of this system, personnel was cut from 14,000 in 1943 to 7,300 in 1945, and tonnage handled increased from 76,530 to 77,969. The tons handled per person also increased from 5.4 to 10.7 for the same period.

NUTRITION REPORT ON CIVILIAN INTERNEES OF JAP PRISONS

American civilian internees of Japanese prison camps in the Philippines, who have recently been returned to the United States, were found in a survey by nutritional scientists of the Army Medical Department to be on the borderline state of extreme starvation.

According to the report, the food served the prisoners, in addition to being poorly cooked, consisted mainly of wilted greens, moldy corn, dirty rice, and a variety of sweet potato, which was often rotten. This soon led to vitamin-deficiency diseases. Relief packages were allowed in the camp only twice during the period of internment, all market vendors were barred from the camp, and the only source of extra rations was the black market.

The report, in listing the effects of malnutrition on the eight children born in the prison camps, noted that only three showed any signs of vitamin deficiency. This was attributed to the mild climate and sunshine of the Philippines. The average weight loss, during the time of internment, jumped from 13.5 pounds in 1942 to 20 pounds in the last six months before liberation.

The most common symptoms still evident in the liberated Americans is digestive upsets, easy fatigability, and neuritis. Seventy-eight per cent of the internees, however, reported that they felt "fine" a few days after liberation. The rapidity of recovery of the adults and the relatively good condition of the children is a striking example of how quickly the human body will return to normal after semi-starvation.

TOTAL STREPTOMYCIN PRODUCTION ONLY FOURTEEN OUNCES A MONTH

The War Department announced that streptomycin, the new wonder sister drug to penicillin, was being used in thirty Army general hospitals over the country, but that it was so difficult to obtain that the total output of the four companies now making it has been only fourteen ounces a month.

Major General Norman T. Kirk, Surgeon General of the Army, said the Army was receiving many requests for the drug for use in treatment of urinary and other infections caused by Gram-negative bacteria which do not respond to penicillin, but that these cannot be met since the Army neither controls the supply nor can get enough for its own needs in treatment of battle-wounded soldiers.

The Army's principal needs are for treatment of soldiers with severed spinal cords who develop urinary tract infections because of a loss of bladder function, and to some extent in treating some cases of meningitis and other infections which do not respond readily to penicillin therapy.

POLICY ON OVERSEAS ASSIGNMENT

Only Army doctors who have not yet been overseas will be given assignments in foreign theaters under the Medical Department policy, Major General Norman T. Kirk, Surgeon General of the Army has announced.

There will also be an age limit for any officer who is to be given an overseas assignment, forty years maximum. He must also have a point score below 45. This revised policy on overseas assignments is part of the new separation policy program just announced by which it is expected more than 13,000 doctors, 25,000 nurses and 3,500 dentists will be released from military service by the end of the year.

ARMY MEDICAL RESEARCH AND DEVELOPMENT BOARD FORMED

A board to be known as the Army Medical Research and Development Board was constituted in the Office of The Surgeon General on 1 September 1945. The Board is to be responsible for the planning and general supervision of all Medical Department research and development activities. Its membership will include the Chiefs of the various professional services and divisions of the Office of The Surgeon General; the Air Surgeon; the Ground Surgeon; the Chairman of the Division of Medical Sciences, National Research Council (by invitation); and the Chairman of the Committee on Medical Research, Office of Scientific Research and Development (by invitation). The Board has two operating divisions, the Research Division and the Development Division, to carry out its plans.

It is the intent of The Surgeon General to carry on an active program of research and development during the postwar period and the new Board should provide

(Continued on Page 1156)

On Antibody Formation

It is well known that severely underfed patients with nutritional edema are excessively susceptible to infections, that infections superimposed on wasting diseases or marasmic states show a rapid, frequently fatal course. In the light of recent findings, both of these facts—heretofore but poorly understood—may well be on the way to conclusive explanation.*

Evidence is rapidly accumulating that antibodies, our chief weapon against infection, are modified proteins of the globulin type. During active immunization, antibody formation presents a continuous process, requiring its share of amino acids.

Experimentally it has been demonstrated that induced hypoproteinemia reduces the capacity to produce agglutinins, precipitins, hemolysins. Adequate protein intake thus gains increasing significance as an essential factor in the resistance to infectious disease.

Among the protein foods of man meat ranks high, not only because of the percentage of proteins contained, but principally because its proteins are of high quality, able to satisfy every protein need.

*Cannon, P. J.: *J. Am. Diet. Assn.* 20:77 (1944)

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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NOVEMBER, 1945

Say you saw it in the Journal of the Michigan State Medical Society

1155

ARMY MEDICAL RESEARCH*(Continued from Page 1154)*

the means for maximum co-ordination of effort within the military service and co-operation with civilian and Federal research agencies. The immediate tasks facing the Board are three in number. Essential research must be continued in the existing Medical Department research and development laboratories in spite of the personnel difficulties of the period of demobilization. Plans must be made and implemented for the continuation or actual expansion of research and development in the postwar period. The demobilization of the Office of Scientific Research and Development necessitated finding other sponsorship for those CMR research contracts which warrant continuation even though hostilities have terminated. A sizable group of these contracts will be taken over by the Medical Department and administered by the Army Medical Research and Development Board.

NEUROPSYCHIATRIC DISCHARGES IN ARMY NOW TOTAL 315,000

The nation's total of soldiers who have been discharged from the Army for neuropsychiatric reasons has now reached 315,000, Brigadier General William C. Menninger, Director of the Neuropsychiatry Consultants Division of the Army Medical Department, said in a recent (October 8) talk before the New York Academy of Medicine.

Describing this problem as a "postwar challenge to medicine," General Menninger expressed the hope that "physicians will prepare themselves to accept and treat what the Army medical officers discovered were among their biggest problems—the emotional factors in the production of illness."

"With this understanding on the part of the physician," General Menninger said, "treatment must be directed towards integrating the individual into his prewar identifications and satisfactions."

On the basis of the Army's experience with neuropsychiatric cases, which are referred to as combat exhaustion or combat fatigue, only about three to five per cent of the soldiers suffered reactions due entirely

to fatigue. The condition of the great majority was primarily a personality disturbance and treated as such, he explained.

Upon induction into the Army a soldier faces an entirely different life which in certain cases produces sufficient stress in the individual to bring him to the psychiatric breaking point.

"Frustration," he pointed out, "was a daily part of the soldier's life, sometimes in the form of waiting days, weeks, months, sometimes in the deprivation of essential supplies.

"Confusion was routine in his life and the noise and whistles and flares of battle are beyond the imagination of anyone who has not heard and seen them."

General Menninger said that essentially the response is the same when an individual fails to adjust himself to his situation in civilian life as it is when he finds he cannot meet the demands of Army life.

ARMY TO RELEASE 12,000 DOCTORS

Brigadier General Raymond W. Bliss, Acting Surgeon General on October 8, 1945, reported that on V-E Day (May 12) the army had 45,500 doctors, and that 2,500 had been released. Releases are to be increased so that the number of doctors in the army by Christmas will be 31,000, and the number will be cut to 15,000 by next July. Among the reasons for not discharging doctors faster are (1) Several thousand are required for separation center work; (2) Several thousand are in transit pending release; (3) Shipping was not immediately available for some doctors eligible for discharge; (4) The patient load in army hospitals in this country has increased since V-E Day; (5) Many doctors who were overworked heavily prior to V-E Day have been given assistance.

The Navy on October 8 also revised its point discharge schedule for doctors. There are now 13,700 in service, and 4,000 will be released under the new plan by January, 1946. Fifty-three points will be required for release, consisting of one-half point for each year of age, one-half point for each month in service, one-quarter point for each month overseas, or at sea, and ten points for dependents.

Appreciation to Michigan's Medical Men in Military Service

The 1945 MSMS House of Delegates adopted by unanimous vote the following resolution concerning medical men from Michigan serving in the armed forces of the United States.

"**BE IT RESOLVED**, That the House of Delegates of the Michigan State Medical Society give recognition to the valiant and super-sacrificing services rendered by the 2,287 Michigan Doctors of Medicine who entered the armed forces in defense of our country; many of these medical officers labored in perilous surroundings and under conditions too terrible to imagine; the State Society wishes these courageous medical soldiers and sailors a speedy return to their home state, now that victory has come to the Allies and the conflict is ended; and be it further

"**RESOLVED**, That the House of Delegates of the Michigan State Medical Society honor those of its members who have made the supreme sacrifice in World War II, by standing for a moment with bowed heads in their memory, and further by requesting the Council to list their names on an appropriate scroll which shall be displayed permanently at the headquarters of the Michigan State Medical Society."

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Political Medicine

MEDICAL CARE FOR THE AVERAGE FAMILY

The problem of assuring unlimited access to modern medical care for families in modest circumstances on a sound American basis long has been clamoring for a solution. Group plans and community plans already in operation to this end in scattered instances do not go far enough fast enough. What is needed is a workable national plan that will assure more protection and cost less.

Unless the men of organized medicine promptly produce one that will protect the Elmers and their families at a cost they can afford, the government is sure to step in and impose a plan that may and probably will be less satisfactory to both the patients and the doctors.

—PAUL HUNTER, Publisher *Liberty*, Sept. 8, 1945.

MEDICAL RACKETS GRIP NEW ZEALAND

Because of abuses, the Government is seriously considering whether New Zealand's free physician service will be continued, Health Minister Arthur Nordmeyer said last night in the House of Representatives.

This governmental admission of widespread racketeering which followed the institution of a system under which any New Zealander may consult any physician as frequently as he likes and the doctor can collect a fee for each visit follows efforts by the National Medical Council to have the Health Ministry act to control what it holds to be an unwarranted drain on the social security fund.

It has been revealed that, though many doctors are still in the armed forces, payments to doctors have been 50 per cent higher than the \$5,000,000 a year that the Government calculated would cover the total annual peacetime cost of medical care.

Moreover, the increasing annual cost of medicines has been alarming the Health Department for the last three years. In addition, figures relating to the cost of medical care previously published by the Health Department have been suppressed for the past two years.

The National Medical Council, which has listed numerous abuses, including "overconsultation," the speedy examinations of patients, some at rates of twelve an hour, payment of \$6,000 a year for one afternoon's work and the charging of a fee for each patient seen on visits to institutions for the aged and the invalid, has been attempting to persuade the Health Ministry to curb these practices.

Government leaders have retorted that the present income taxes, which go as high as seven-eighths of all earnings, enable the Government to recover most of the money paid to such doctors. The Health Ministry has nevertheless concealed the doctor's high earnings from Parliament, disclosing only the sums paid from the social security fund to unnamed individuals and ignoring the fact that the present system means that patients must meet at least three-tenths of the cost of each consultation.

Because the Government has failed to institute a system of surgical care unless the patient can be admitted to overcrowded, publicly financed hospitals, doctors have conspired with persons entering private hospitals to help build substantial State aid toward the payment of surgical fees, it has been charged.

The Government, which originally strove to employ physicians on the basis of a fixed annual fee for each patient, is believed determined to put doctors on a fixed income. Parliamentarians emphasize that since free medical care began New Zealand has created the biggest hospitalization setup in the world—*The New York Times*, Oct. 5, 1945.

PUBLIC MEDICAL CARE MEANS REGIMENTATION

Dr. Wilford L. King, Professor of Economics of New York University, in a statement sent to all members of Congress, and released to the public press, declares certain demands of some labor unions, "can result only in ruinous inflation, eventual state socialism and destruction of the labor unions."

Conceding that there is much to recommend compelling every citizen to insure himself against reverses, Dr. King points to the existence of private insurance companies as offering "no excuse for putting the government into the insurance business." He says that "our existing social security system is not constructed on sound insurance principles," and that "it invades private property rights by compelling certain citizens to contribute to the support of other citizens. All strengthens the move toward Socialism."

Speaking of "Public Medical Care," he says: "When government takes over any function, the citizens gradually lose all control of the way that function is administered. Presumably, therefore, medical treatment will gradually be regimented to suit the whims of the administrators."

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Penicillin in the Treatment of Syphilis

By S. William Becker, M.S., M.D.

Chicago, Illinois



THE TREATMENT of syphilis by penicillin was first reported by Mahoney, Arnold and Harris¹, who treated four patients with primary syphilis by means of 25,000 units of penicillin injected intramuscularly every four hours for a total dosage of 1,200,000 units. The penile chancres healed promptly and the serologic reactions were all negative within three months after institution of treatment.

On the basis of these excellent results, penicillin therapy has been instituted (under the general auspices of the Office of Scientific Research and Development and under the specific direction of the Penicillin Panel, of which Dr.

Read at the 79th Annual Session, the Fourth Annual Postgraduate Conference on War Medicine, Michigan State Medical Society, Grand Rapids, Michigan, September 29, 1944.

From the Chicago Intensive Treatment Center, H. Worley Kendell, Surgeon (R) USPHS Medical Director, a facility of the Venereal Disease Control Program of the Chicago Health Department, Herman N. Bundesen, M.D., President.

The penicillin was provided by the Office of Scientific Research and Development from supplies assigned by the Committee on Medical Research for clinical investigations recommended by the Committee on Chemotherapeutics and Other Agents of the National Research Council.

J. E. Moore is chairman, appointed by the Subcommittee on Venereal Diseases, National Research Council). It has been my privilege to supervise the penicillin treatment of early syphilis at the Chicago Intensive Treatment Center, where patients have been treated with penicillin alone and with a combination of penicillin and mapharsen. Since our results were pooled with those of other treatment centers throughout the United States, it will be more informative to review briefly the results presented at a symposium on penicillin therapy at the meeting of the American Medical Association in June of this year. The striking response in two of our patients with precocious tertiarism will be presented in some detail. A complete report of our results will be included in a Progress Report of the Chicago Intensive Treatment Center.

In a follow-up report on the four patients already mentioned, Mahoney et al.² stated that three patients remained clinically and serologically negative; the fourth developed, nine months after treatment, an ulcerative, darkfield positive lesion on an indurated base, on the inner surface of the lower lip, associated with regional lymphadenopathy. The authors very conservatively classed the case as one of relapse, although the probability of re-infection is great and might conceivably have been confirmed by further observation without treatment. The patient was re-treated with penicillin. Mahoney et al. further reported on an additional group of approximately 100 patients, all but three (acute arsenical intoxications) of whom had proven early syphilis, who were treated with 20,000 units of penicillin every three hours for a total of 1,200,000 units. All lesions healed promptly. Of fifty-two patients followed over seventy-five days (average 135 days), thirty-one experienced serologic re-

versal. The remaining 21 patients still had positive blood tests, in seven (possibly nine) of whom therapeutic failure was heralded by upward progression of the quantitative titer.

Moore et al.³ reported the pooled results, including those obtained at the Chicago Intensive Treatment Center, on 1,418 patients from twenty-three treatment centers studying the effect of penicillin on early syphilis in human beings. Sodium penicillin was administered every three hours for a total of sixty injections. The individual doses varied from 1,000 to 20,000 units, total dosage from 60,000 to 1,200,000 units. A few patients were given 40,000 units per injection for a total of thirty injections (total dosage 1,200,000 units). Twenty-five patients were treated intravenously for a period of from four to eight days.

Pooled Results of Penicillin Treatment in Early Syphilis

All lesions healed promptly. With a total dosage of 60,000 units in eight days healing was less prompt than following efficient arsenical therapy; with total dosage of 300,000 units and over, healing was as rapid as with standard chemotherapy or more so.

The time of disappearance of *Treponema pallidum* from surface lesions varied from an average of thirteen hours with 20,000 unit individual doses to twenty-one hours with individual doses as low as 1,000 units.

The serologic response was satisfactory (reversed to negative or falling quantitative titer) in up to 90.3 per cent of patients receiving 1,200,000 units as compared with 57.8 per cent of patients receiving a total of 60,000 units. Serologic reversal occurred at about the same rate as following arsenical therapy.

Relapse in patients observed for more than thirty-eight days varied from 2.0 per cent in those who received 1,200,000 units to 28.2 per cent in those receiving only 60,000 units.

On the basis of experience with other methods of syphilotherapy, with the thought that penicillin-resistant cases would be encountered, two series of patients were treated with a total of 60,000 and 300,000 units of penicillin, respectively, along with 0.320 G. of mapharsen, over a period of eight days. Serologic response following such treatment was slightly the best in the entire series, and relapses were fewer, although the

number of patients (sixty-eight) was small. Such combined therapy had been discontinued temporarily when it became apparent that penicillin-resistant cases were not being encountered. It is possible that such a combination of penicillin and mapharsen will prove more effective than either one used alone.

Ten of thirteen patients with early asymptomatic neurosyphilis showed improvement in cerebrospinal fluid findings or reversal to normal. Favorable results were obtained in ten patients with acute syphilitic meningitis.

Twenty infants with early prenatal syphilis have been treated with a total of 20,000 units per kilogram of body weight, which dosage is comparable to that used for adults. The response was similar to that seen in early acquired syphilis.

Eight patients with treatment-resistant early syphilis have been treated with penicillin, with response comparable to that in untreated early syphilis. The following two patients belonging in this group were treated at the Chicago Intensive Treatment Center.

Case Reports

Case 1.—Mr. C. E. M., white, aged seventeen, developed a penile lesion in the latter part of October, 1943. The Kahn reaction of his blood serum was reported to have been positive on December 17, 1943. Diagnosis of early syphilis had been made. He had been given four intravenous injections of an arsenical preparation at weekly intervals, along with two intra-gluteal injections of bismuth, the last on January 29, 1944. He stated that he had developed a cutaneous eruption on January 3, 1944, at first on the legs, then on the forearms and back. He was first seen at the Clinic on January 17, 1944, at which time he presented pronounced erythema and swelling of the penis, especially of the distal portion. An ulcer was present beneath the edematous foreskin, which discharged purulent material. There was right inguinal adenopathy, with generalized indolent adenopathy. He complained of laryngitis of two weeks' duration and stated that he had lost fifteen pounds in three months. On the face, back, arms, legs and thighs were scaling, papulopustular and rupial lesions. On the legs were ulcers. There was an ulcer on the left side of the soft palate near the tonsil. General physical examination revealed tachycardia, which was revealed by electrocardiogram to be of sinus origin.

Laboratory findings: Darkfield examination of serum from the penile ulcer revealed no *Treponema pallidum*, but DuCrey bacilli were found on culture. The quantitative Kahn reaction of the blood serum revealed 20 units. Blood examination showed: hemoglobin, 15 G.;

leukocytes, 11,200; differential count—polymorphonuclear leukocytes, 66 per cent; lymphocytes, 24 per cent; eosinophilic leukocytes, 4 per cent and monocytes, 6 per cent. The urine contained a few erythrocytes and pus, grade ii. The spinal fluid was normal on examination.

Diagnosis was made of secondary syphilis with premature tertiarism and chancroidal infection. He was given three injections of mapharsen in doses of 0.040, 0.055 and 0.055 G., and two injections of bismuth subsalicylate in dose of 0.075 G. from January 21 to 29, inclusive. Because this treatment produced no apparent improvement and since his previous treatment, though inadequate, had been followed by development of premature tertiarism, the condition was classed as a treatment-resistant relapse and he was placed on penicillin. He received 600,000 units in seven and one-half days. For treatment of his chancroidal infection, he was given sulfathiazole previous to and sulfadiazine following penicillin therapy. Administration of the former was followed by appearance of erythema nodosum-like lesions on the legs, and the latter by a generalized urticarial eruption. Discontinuance of the drugs was followed by disappearance of the medicamentous eruptions.

During penicillin therapy, the blood count showed: hemoglobin, 13.7 G.; erythrocytes, 4,800,000; leukocytes, 18,000 and differential count: polymorphonuclear leukocytes, 80 per cent, lymphocytes, 10 per cent, eosinophilic leukocytes, 2 per cent, basophilic leukocytes, 2 per cent and monocytes, 6 per cent. The quantitative titer of the blood serum was 40 Kahn units. On discharge, 19 days after institution of treatment, the Kahn quantitative reaction was four units. At that time, many of the cutaneous lesions had healed, the remainder were healing, with the exception of the chancroidal ulcer, which was practically unchanged. There was improvement in his sense of well-being. A communication from his physician, dated September 19, 1944, stated that he is working and apparently feels well. His Kahn test is negative and he has had no further trouble with the exception of a cutaneous eruption of unknown nature, which has now cleared up.

Case 2.—Mr. R. B., white, aged thirty-four, was admitted to the C.I.T.C. on February 18, 1944, with psoriasiform and rupial lesions on the face, arms, chest and abdomen. There were huge condylomata on the thighs, perineum, scrotum and perianal regions. Large ulcers were also present on the scrotum and perianal regions, covered with thick, foul-smelling pus. He had been exposed three months prior to admission and had had lesions for 11 weeks. Darkfield examination of serum from the condylomata was positive for *Treponema pallidum*. The quantitative Kahn titer of his blood serum was 600 units. The spinal fluid was negative on examination. Diagnosis was made of secondary syphilis with premature tertiarism. He was treated by means of penicillin (300,000 units in seven and one-half days) and mapharsen (0.320 G. in seven days.)

Twenty-four hours after treatment was started, dark-field examination was negative; in forty-eight hours,

the purulent discharge had decreased; in seventy-two hours, a majority of the lesions were dry and all had markedly involuted; all were epithelialized. Eight days after treatment was instituted, three-quarters of the condylomata had completely healed; the remaining one-quarter had receded to one-third the original height. At that time the quantitative Kahn titer of the blood serum was still 600 units. The lesions healed, leaving pigmented macules. The titer of the blood serum gradually decreased, and was four units when he was last seen on September 9, 1944.

Reactions to Penicillin

Fifty-nine per cent of patients had Herxheimer reactions within the first twenty-four hours, which reactions consisted either of fever alone or exacerbation of the early syphilitic cutaneous eruption, with or without fever. Other reactions occurred in 4.1 per cent of patients. There were eight urticarial eruptions, seven other cutaneous eruptions, none severe, seven cases of mild gastro-intestinal disturbances, thirty-three instances of secondary fever, two of abscessed buttocks and two miscellaneous mild disturbances. No reaction was sufficiently severe to necessitate discontinuance of treatment.

Results of Penicillin Treatment in Late Syphilis

Stokes et al.⁴ reported that penicillin had been used in treatment of 182 patients with late syphilis, of which 122 had neurosyphilis.

Twenty-one patients with gummatous syphilis of the skin or bones were treated with a total dosage of 300,000 units. The lesions in 13 patients were healed 100 per cent; in two, 75 per cent; in four, indefinite results were obtained and two were classed as treatment failures. In the successful cases, healing took place in from 12 to 46 days. It is probable that the penicillin also aided in controlling the secondary infection present in this type of lesion.

Patients with neurosyphilis were treated with a total dosage of from 600,000 to 4,000,000 units of penicillin over a period of about eight days.

Regardless of the dosage, the quantitative serologic titer of the blood serum was reduced in 50 to 60 per cent of ninety-six late cases (excluding latent syphilis). An initial Herxheimer rise or "provocative effect" was seen in 20 per cent of late cases.

Abnormal findings in the cerebrospinal fluid improved in 74 per cent of cases. Twenty-four of thirty patients with the simple demented type

of general paresis improved clinically, but only three of ten deteriorated paretics showed any improvement. In tabes dorsalis, one-fifth of fourteen patients improved 50 per cent or more. Patients who had received previous treatment of various kinds, including fever treatment, showed no difference in response to penicillin.

Of fourteen patients with interstitial keratitis in late prenatal syphilis, six improved and two became worse. Two patients with optic neuritis improved. Two patients with iritis improved 100 per cent; one relapsed and did not respond to further treatment by penicillin. Two patients with eighth nerve deafness gave indefinite results. One patient with Charcot joint experienced involvement of an additional joint after treatment.

In treatment of late syphilis, Stokes et al. state that therapeutic shock should be guarded against by reduced dosage of penicillin during the first twenty-four to forty-eight hours.

Discussion

In preliminary studies on the treatment of early syphilis by penicillin, the drug appears to combine a high index of therapeutic effectiveness with low toxicity. The absence of penicillin-resistant infections has been gratifying. The drug rapidly causes (a) disappearance of surface organisms from open lesions, (b) healing of lesions and (c) a trend toward serologic reversal. The incidence of relapse following penicillin alone has been least with total dosage of 1,200,000 units. The lowest incidence of relapse—and the most favorable serologic response—was in small groups of patients treated by a combination of penicillin and mapharsen. The chief drawback to the use of penicillin in routine treatment of early syphilis, if and when it becomes available for this purpose, is the necessity for hospitalization for a total of seven and one-half days to receive eight injections daily which have thus far been deemed necessary. A recent report by Romansky and Rittman⁵ of suspension of calcium penicillin in mixtures of beeswax and peanut oil, injection of which is followed by a sustained penicillin blood level for six to seven hours seems to constitute a significant step in the direction of making penicillin available for office treatment.

In late syphilis, less rapid and less uniform response than in early syphilis is obtained, regardless of the method of therapy used. This same

difference has been noted in preliminary studies on penicillin treatment of patients with various types of late syphilis. However, results in both early and late syphilis have been encouraging and the studies are being continued.

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MSMS

Recent Advances in the Treatment of Syphilis

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and

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ARTHUR C. CURTIS, M.D.

IN VIEW of the rapid strides which have been made in the treatment of syphilis, it becomes highly important for the practitioner to know what form of therapy can be best adapted to his patients and also what is the risk and the ultimate result of such treatment.

Rapid Treatment in Acute Syphilis

In 1931, Hirshfeld, Hyman and Wanger⁵ showed that the rapid intravenous introduction

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of pharmacologically inert chemicals, drugs and biologic fluids might give rise to alarming symptoms and at times fatal results. This was known as "speed shock" and was characterized by a rapid and precipitous fall in blood pressure, usually transitory but occasionally fatal; respiratory distress manifested either by simple dyspnea, apnea with atelectasis or bronchial spasm and non-coagulation of the drawn blood. Autopsies done on the experimental animals which had received solutions by this method, revealed multiple punctate hemorrhages in the viscera, fresh thrombi in the pulmonary vein and either atelectasis or emphysema of the lungs. If these same solutions were introduced intravenously into an animal at the rate of 2 or 3 cubic centimeters a minute, "speed shock" did not occur and it was found that even substances as toxic as histamine could be introduced in this manner. In 1933, Chargin, Leifer and Hyman¹ applied these facts to twenty-five patients who had acute syphilis. Over the course of five days there was introduced, by means of the intravenous drip, 4 grams of neoarsphenamine. Febrile reactions, toxicodermas and mild gastro-intestinal symptoms, namely, nausea and vomiting, occurred in the majority of patients. There was no immediate or delayed liver or renal damage but one-third of the patients developed a rather extensive and sometimes incapacitating polyneuritis. In this series, eighteen of nineteen patients were serologically negative at three months. One who received only 2.9 grams of neoarsphenamine was still positive at three months and six patients were lost to follow-up. Five years later Hyman, Chargin, Rice and Leifer⁶ reported a restudy of this group of patients. Fifteen of these patients were re-examined on or about the fifth year. Twelve were seronegative. One had additional treatment so that the results of massive arsenotherapy cannot be appraised in this case. Two were reported as re-infected.

In this same report, but in another series of cases treated by the same method, Hyman, Chargin, Rice and Leifer⁶ reported the first fatality from hemorrhagic encephalitis due to massive arsenotherapy. They emphasized the high toxicity of this form of treatment, but they also drew attention to the greater convenience, the shortened period of infectivity and the advantage of removing the syphilitic person from circulation during the infectious stage.

In the meantime, Tatum and Cooper¹⁶ had interested themselves in an arsenical compound which had been studied earlier by Erlich and discarded because of its toxicity. Knowing that the arsenicals which had proven effective in the treatment of syphilis were probably broken down by the liver into arsenous oxide, they began a pharmacological study of a compound chemically known as meta-amonio-para-hydroxy-phenylarsine-oxide (mapharsen). The experimental work with this drug was so promising and its toxicity so low, it was used in the treatment of human syphilis by Foerster, McIntosh, Wieder, Foerster and Cooper.⁴ Later others^{2,7,11,12,15} found mapharsen to be a satisfactory antisyphilitic drug. The combination of drip therapy with an effective but less toxic antisyphilitic drug stimulated physicians in many medical centers to use this form of treatment for acute syphilis.

Recently the United States Public Health Service¹⁹ has presented the results of various types of massive arsenotherapy in 4,351 cases. The results show 85 to 90 per cent cure in primary syphilis and 70 to 85 per cent cure in secondary syphilis, with a mortality of 3.9 per 1,000.

At the University Hospital, five-day massive arsenotherapy was used for a period of two years. The procedure used consisted of dissolving 240 mgm. of mapharsen in 2,000 c.c. of 5 per cent glucose. This solution was allowed to drip slowly into the patient's veins at the rate of 3 or 4 c.c. per minute, for a period of eight to ten hours. The same procedure was repeated each day for five days. In addition, the patient had one injection of 130 mgm. of bismuth subsalicylate in oil at the beginning and end of treatment. The total dose of mapharsen given over the five-day period was 1,200 mgm. and the total dose of bismuth, 260 mgm.

In a series of 340 cases so treated, case follow-up is sometimes difficult. However, 277, or 81.4 per cent, have been kept under study. The results can best be divided into primary, early secondary and late secondary syphilis.

Results of Rapid Treatment. Primary Syphilis (Five-day)

This group consisted of 104 cases. Twenty-four were seronegative at the beginning of treatment and eighty were seropositive. There were seventy-nine males and twenty-five females. The age group varied from eleven to forty-seven years.

Darkfields were all positive in the seronegative group and 93 per cent positive in the seropositive group. All spinal fluids were negative except for one patient in the seropositive group who had a group II spinal fluid. All of the nineteen seronegative cases followed (79 per cent) remained seronegative throughout a period of eighteen months. Of the eighty seropositive cases, sixty-five (81.2 per cent) were followed and fifty-eight became seronegative and remained so for a period up to thirty months. In the seropositive group, there were seven relapses. Four of these were clinical and three serological and all occurred from two to eight months after treatment. There was one unquestionable reinfection. The percentage of satisfactory treatment obtained was 100 per cent for the seronegative primary syphilis group and 89.2 per cent in the seropositive primary syphilis group.

Results of Rapid Treatment. Early* and Late Secondary Syphilis† (Five-day)

In early secondary syphilis there were 211 cases, of which sixty-eight were males and 143 females. The age varied from four to sixty-seven years. Seventy-five per cent were dark-field positive. All patients were seropositive and the serological titer ranged from three to 1120 units. The spinal fluids were negative except in five instances. Three patients had Group I and two Group II spinal fluids. One hundred and seventy-three patients, or 82 per cent of the group treated, were followed. Of these 87.9 per cent became and remained seronegative for a period up to 39 months. In this group there were twelve serological and six clinical relapses and two deaths.

In the late secondary syphilis group there were twenty-five cases, six males and nineteen females. The age group varied from eleven to fifty-three years. Of these 65 per cent were darkfield positive. All bloods were seropositive, ranging from ten to 560 units in quantitative titer. The spinal fluids were negative except in five instances. Three spinal fluids had Group I and two Group II reactions. We have been able to follow twenty (80 per cent) of the cases treated. Eighteen cases were followed for periods up to two years. Two cases (10 per cent) relapsed.

*Early secondary syphilis is defined as syphilis of not more than six months' duration.

†Late secondary syphilis is defined as syphilis of from six months' to two years' duration.

TABLE I

Total cases—340. Males—153. Females—187. Age groups—4 to 67 years.

Toxic Reactions

(1) Nausea and vomiting	87.0%
(2) Primary fever	30.0%
(3) Secondary fever	20.0%
(4) Toxicoderma	5.0%
(5) Neuritis	2.3%
(6) Nitritoid	0.25%
(7) Mapharsen encephalopathy	1.2%
(8) Hemorrhagic encephalitis and death ..	0.5%
(9) Thrombosis of spinal artery	0.25%

Results

	<i>Satisfactory</i>	<i>Unsatisfactory</i>
Seronegative primary syphilis	100%	0
Seropositive primary syphilis	89.2%	10.8%
Early secondary syphilis	38.1%	11.9%
Late secondary syphilis	90.0%	10.0%

One was clinical and serological at five months and one was serological with neuro-involvement at fifteen months.

Our results for all cases and types of early syphilis treated by the five-day drip method are summarized in Table I. The results of therapy are reported only for the primary and secondary types of syphilis.

During the latter months of the use of five-day massive arsenotherapy, it became apparent that the danger of hemorrhagic encephalitis was a real one and frequent enough so that it might detract from the value of the treatment. Our mortality with the five-day treatment in 353 cases is 0.84 per cent. In an attempt to determine whether there might not be some way this complication could be anticipated¹⁰, the following studies were done consecutively on the next 59 patients. A complete blood count, clotting time, bleeding time, prothrombin time, blood vitamin C determination, positive pressure tourniquet test (Rumpel-Leede) and a negative pressure test on the skin. These examinations were done routinely on the day of admission, the first, third and fifth day of treatment and oftener if any clinical signs or symptoms pointed to the development of any encephalopathy. During the period of study there were six cases of either mapharsen encephalopathy or encephalitis and two deaths. None of the patients showed any consistent abnormality of the several procedures done with the exception of the positive pressure tourniquet test. In all but one case the positive pressure tourniquet test showed petechial hemorrhage before the development of the symptoms or signs of hemorrhagic encephalitis. Since that time, the positive pressure tourniquet test has been used routinely on all patients receiving massive arsenotherapy and the treatment is discontinued immediately upon the appearance of petechial hemorrhages be-

low the blood pressure cuff. There has been no fatality from massive arsenotherapy since that time.

In the management of a large series of cases receiving intravenous drip, it is not always possible to check the speed of the drip. It was noted that some patients, after receiving the drip for one or two days, would unscrew the bulldog clamp themselves so that the drip would go faster and shorten the time of their day's treatment. It would seem logical to assume that some cases developed hemorrhagic lesions in the brain, as well as elsewhere, from a combination of "speed shock" and the vasculo-toxic effect of the arsenical itself. In an attempt to correct the latter, a modification of massive arsenotherapy was introduced which consisted in giving 240 mgm. dissolved in 1,000 c.c. of 5 per cent glucose for the first day and then 120 mgm. of mapharsen dissolved in 2,000 c.c. of 5 per cent glucose for the next seven days, making a total of 1,080 mgm. of mapharsen. This extends the time to eight days and in addition to arsenotherapy, 1 c.c. of bismuth subsalicylate was injected intramuscularly the first, third, sixth and ninth days of treatment. The incidence of toxic reactions in this group is less than with the five-day treatment. In the first 171 cases followed, no serious reactions occurred.

Results of Rapid Treatment. Primary Syphilis (Eight-day)

There were sixty-two patients with primary syphilis treated by the eight-day method. All spinal fluid examinations were negative. Twenty-five patients were seronegative and all were darkfield positive for *treponema pallida*. Of the 25 patients who were seronegative but darkfield positive, 17 or 68 per cent, were followed up to six months. All remained seronegative and clinically negative. There were thirty-seven seropositive cases, 93 per cent darkfield positive, ranging from one to 520 quantitative units. We have followed thirty-three of the thirty-seven cases, or 89.1 per cent. There have been five who have relapsed or become re-infected (15.1 per cent) and one proven re-infection. All others have become and remained seronegative.

Results of Rapid Treatment. Early and Late Secondary Syphilis (Eight-day)

In the early secondary syphilis group, there were ninety-three cases, ranging in age from

TABLE II

Total cases—171. Males—123. Females—48. Age group—13 to 64 years.

Toxic Reactions		
(1) Nausea and vomiting	19.3%	
(2) Primary fever	29.2%	
(3) Secondary fever	20.4%	
(4) Toxicoderma	22.8%	
(5) Peripheral neuritis	0.58%	(1 case)
(6) Headache	1.7%	
(7) Deaths	0	
Results		
	Satisfactory	Unsatisfactory
Seronegative primary syphilis	100%	0
Seropositive primary syphilis	84.9%	15.1%
Early secondary syphilis	90.9%	9.1%
Late secondary syphilis	77.8%	22.2%

thirteen to fifty-five years. There were twenty-six males and sixty-seven females. All patients were seropositive and the serological titer ranged from three to 720 quantitative units. Two spinal fluids were positive, both of Group I type, and 80.6 per cent were darkfield positive. Of the ninety-three cases treated, seventy-seven (83.6 per cent) were followed. Of these 90.9 per cent showed satisfactory improvement or seronegativity up to twelve months. There were seven relapses, occurring four to eight months following treatment. Three were serological, four were clinical and serological. There were three probable reinfections.

Sixteen patients with late secondary syphilis were treated by the eight-day drip method. Seven were males, nine were females. The age group varied from eighteen to thirty-eight years. All were seropositive, ranging from 20 to 520 quantitative units. One spinal fluid was positive of the Group II type, and 56.2 per cent were darkfield positive. Nine (62.5 per cent) of the cases were followed. Of these, seven (77.8 per cent) showed satisfactory clinical and serological improvement up to ten months. There were two relapses at four months, following treatment. One was serological and one was clinical and serological. A summary of our results in all cases of early syphilis treated by the eight-day drip method is shown in Table II.

We have retreated thirteen cases of re-infection and relapse with the five-day treatment. Eight cases have been followed up to ten months. Three have relapsed or were re-infected. If all were considered relapses, 37.5 per cent have not responded to retreatment. There was one death from hemorrhagic encephalitis. Seven cases have been retreated by the eight-day schedule and six have been followed up to twelve months. All have progressed satisfactorily.

Our mortality with the five-day treatment in

353 cases is 0.84 per cent. There have been no deaths to date with the eight-day treatment.

Rapid Treatment, Eagle Method

In 1943, Eagle and Hogan³ reported in *Veneral Disease Information* the results of a modified form of rapid therapy. Their treatment consists of the injection of 40 to 80 mgm. of mapharsen three times weekly, depending on the patient's weight, for a period of eight or twelve weeks, plus the weekly injection of 1 c.c. (.2 gm.) of bismuth subsalicylate throughout the course of treatment. This gives a total of from 1,800 to 2,520 mgm. of mapharsen and 1,040 to 1,560 mgm. of bismuth subsalicylate. The results in the Eagle and Hogan plan are essentially the same as in the other plans of rapid therapy and the mortality is estimated at from 0.1 to 0.4 per cent.

Rapid Treatment, Army Method

Turner and Sternberg¹⁸ reported in the *Journal of the American Medical Association* the Army Plan for rapid treatment. This plan consists of giving two weekly injections of mapharsen for a period of ten weeks, plus five weekly injections of bismuth subsalicylate during the first five weeks of this period. This is then followed by six weekly bismuth subsalicylate injections, then two weekly mapharsen injections plus five more weekly bismuth subsalicylate injections during the last five weeks. The whole course takes twenty-six weeks. The recommended individual dose of mapharsen is 60 mgm. and of bismuth subsalicylate 0.2 grams. They state that their system is merely a modification of older ones and the total amount of arsenous oxide administered is about the same (2,400 mgm.). It is assumed by them that the end results will not differ significantly and that cures will be effected in not less than 85 per cent of cases of early syphilis.

There are many other modifications of rapid therapy such as that recommended by Schoch and Alexander¹⁴, by Thomas and Wexler¹⁷ and the one-day method of Rose, Simpson and Kendall¹³, which will not be discussed at this time.

Rapid Treatment, Penicillin

In 1942, Mahoney, Arnold and Harris⁸ reported on the treatment of four patients having acute syphilis who received by intramuscular injection 25,000 Oxford units of penicillin at four-

hour intervals for forty-eight injections. The total amount of the substance used was 1,200,000 Oxford units and the total time of therapy eight days. Three of the four patients experienced rapid healing of penile ulcerations and attained seronegativity within the initial three months of observation. The fourth patient likewise experienced prompt healing of the penile lesion and serological reversal on the seventy-first day. On the 286th day of observation, this patient had strongly positive reactions and a specific urethritis. Although in all probability this patient had a re-infection, Mahoney, being extremely cautious, has classified this patient as a treatment failure. Recently Mahoney, Arnold, Sterner, Harris and Zwalley⁹ have reported further studies on 100 patients treated with penicillin. The treatment routine used for these patients was modified only slightly from the former regimen. They received 20,000 Oxford units of penicillin administered at three-hour intervals night and day for sixty injections, the duration of treatment being seven and one-half days.

The total amount of penicillin employed was 1,200,000 Oxford units. Herxheimer-like reactions, or therapeutic shock, of varying degrees of severity were observed during the first day of treatment in eighty-six patients. All cutaneous lesions of syphilitic nature were epithelized at the time of completion of treatment. No severe toxic reactions were encountered, although two cases had a mild exfoliative dermatitis which was believed to be due to the impurities in the penicillin rather than to the penicillin itself. Doctor Mahoney and his group reported on those patients who had been followed for a period of seventy-five or more days. This included fifty-two patients from the original 100. The average duration of observation in this group was 135 days. Six of the fifty-two patients were darkfield-positive seronegative cases and all remained seronegative. Twenty-five patients who were seropositive showed an average time for reversal of their serology of seventy days. This makes a total of thirty-one patients who can be considered as having responded in a favorable manner to the therapy during this short interval. Seven patients showed a progressive decline in the serological titer without any tendency for a return to a high titer reaction. In another group of seven patients there was a trend toward seronegativity and then unmistakable evidence of

a return to higher titer reactions. They were considered as serological relapse. The remaining seven patients he has classified as displaying serological patterns which rendered it difficult for them to make a favorable or unfavorable classification at the time they reported the cases. In his comment, Mahoney stated that it was his impression that very early infections responded in the most favorable manner to penicillin therapy and that the increase in the number of probable failures in patients with secondary syphilis indicated to him the need of a more vigorous therapy than that used in his original report. Certainly a relapse rate of 13 per cent in four and one-half months upholds his contention in this regard.

At the University Hospital some cases of acute syphilis are being treated with penicillin therapy, under the direction of Mahoney. His recent recommendation that a total dose of 2,400,000 Oxford units of penicillin be given is being followed in this Clinic. At present our cases have not been observed long enough to make a statistical report.

Discussion and Conclusion

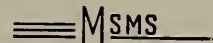
In advising a patient with acute syphilis what form of therapy should be used, several things must be considered. Experience has shown that good results with a minimum of danger can be obtained by prolonged treatment schedules in the co-operative patients. In migratory, unco-operative and promiscuous patients, continued activity of the disease or infectious relapses are problems which cannot be satisfactorily controlled unless treatment is adequate. In this group, semi-intensive or intensive therapy is recommended. Although the dangers from complications are more common with rapid therapy, infectiousness and progress of the disease is more rapidly controlled to justify its use. Eventual mortality from cardiovascular and central nervous system syphilis in the group having had rapid treatment compared to a similar group treated by routine methods would be interesting to know. Another advantage of rapid therapy is that 98 per cent of those who begin it, complete it all. This is certainly several times as high as that per cent who begin and complete the entire course of routine treatment.

Penicillin holds great promise as an anti-syphilitic substance. It has none of the serious complications of the trivalent arsenicals and more nearly simulates the ideal anti-syphilitic drug than

any yet introduced. What will be its eventual value and what will be the optimum dosage and method of administration in the various types of syphilis are still facts to be learned.

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"COMPULSORY HEALTH INSURANCE"—TRUMAN

Twenty-six state medical society presidents have proposed a plan for health insurance to the nation that will obviate the necessity for compulsory plans. Minimal amendments to the social security acts are necessary; also recognition by government of voluntary prepayment plans, encouragement of private foresight by individual Americans to provide for their health needs in methods now available, and assumption of responsibility for the indigent and low income group. These principles will be published soon.—EDITOR.

The Treatment of Sulfonamide-Resistant Gonorrhea With Penicillin as a Clinic Routine

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IN a comparatively short space of time, the entire concept of the treatment of gonorrhea has undergone such a complete transition as to render the time-honored Valentine irrigator, with its burgundy-colored contents and the stain-producing urethra injections, museum pieces of other days. This change has been brought about by the advent of the sulfonamide group and, more recently, by the use of penicillin. Penicillin has the added advantage that side reactions and the drug-resistant factor are rarely encountered.

There is abundant evidence that, if sufficient amount of penicillin is administered over a period of twelve or more hours, a high rate of cure results.^{1,2,3} However, to make it available to the average gonorrheal patient, the time element must be abbreviated so as to render office and clinic administration of the drug practical during working hours. Recent reports evaluating the efficacy of a shortened span of treatment hours have appeared in the literature.^{4,5} Because of the disturbing frequency with which sulfa-resistant gonorrhea was encountered at the Social Hygiene Clinic of the Detroit Department of Health, it was decided to administer penicillin to these cases whenever the drug was available. The treatment was confined to the clinic hours.

Material

This report includes ninety-seven cases, of which eighty-seven were men and ten women.

Read before the Detroit Branch of The American Urological Association, November 15, 1944.

All were between the ages of seventeen and fifty-seven; 70 per cent were negroes. In addition, twenty-six patients were treated who failed to report for post treatment follow-up and, therefore, cannot be included here. We may assume, however, that in many of these delinquents the clinical response was good, otherwise some would have returned for further treatment because the average clinical patient is quite critical of lack of progress. All patients accepted for this study had failed to respond to two or more courses of a sulfonamide—each course consisting of 20 grams administered over a five-day period. In addition, there was bacteriological proof of gonococcal infection immediately prior to Penicillin Therapy.

Method of Administration

The sodium salt of penicillin was dissolved in distilled water, in the strength of 100,000 Oxford units per 10 c.c. The individual dose varies from 20,000 to 50,000 units. The upper and outer area of the gluteal muscle was selected for alternate injections, using a 22-gauge, 1.5-inch needle.

Criteria of Cure.—A smear and a culture were taken on the 7th, 14th and 21st days post treatment. Bacteriologic studies were made from the material obtained from the following sources: urethra, prostatic secretion, or urinary sediment. Three (3) consecutive negative findings were considered as evidence of cure.

Plan of Treatment.—In both schedules 1 and 2 the total amount of the drug used was 100,000 units, with individual doses of 20,000 and 25,000 units, respectively, and with a time spacing of two hours in schedule 1 and three hours in schedule 2. Schedule 3 total dosage was 120,000 units of 40,000 each given at three-hour intervals. Schedule 4 used a total dosage of 150,000 units divided into 50,000 units given every three hours. Since the penicillin is dispensed in ampules of 100,000 units each, and since the treatment used in schedule 3 left 80,000 units unused, this schedule was discontinued. Hence the small number of patients in this group.

Results of Treatment

The clinical response to penicillin in the majority of cases was most dramatic. A noticeable improvement in both the objective and the sub-

jective symptoms was observed even before the treatment was completed. Occasionally a slight mucoid urethral discharge persisted for three or four days and then disappeared spontaneously. This might be interpreted as a manifestation of lagging tissue repair as compared to a bacteriologic response.

The results obtained in the four groups will be considered separately:

Group 1—Thirty-three patients, consisting of three women and thirty men. Of these, thirty-two satisfied the criteria of cure, showing a rate of cure of 97 per cent.

Group 2—Twenty-one patients, all men, with a rate of cure of 90 per cent.

Group 3—This group was so small that it is hardly fair to compare the results with the larger groups, but it is included as part of the entire study. It contained three cases with one failure, giving a rate of cure of 66 per cent.

Group 4—Forty patients, seven women and thirty-three men. There were four failures⁴, giving a rate of cure of 90 per cent.

All groups, with the exception of Group 3, show a rate of cure of 90 per cent or better. For the total of ninety-seven patients, the combined rate is 91.7 per cent.

Seven treated cases were classified as re-infections because the positive evidence of gonorrhea occurred between four and eight weeks after treatment. Several of these patients frankly admitted recent sexual exposure. Five of the failures received a second course of penicillin with satisfactory results. In no cases treated was there any suggestion of a drug-resistant factor. Cohn and Siejo⁶ support this observation by their experiments *in vitro*, using penicillin in 1 to 10,000 dilutions which killed all gonococcus strains tested. Except for some transitory pain at the site of injection and an occasional attack of slight dizziness, the reactions were insignificant.

Results of Treatment

In the accompanying table it will be noted that four different schedules of treatment were used.

TABLE OF RESULTS

Group	Total Dose	Individual Dose	Time Spacing Hrs.	Total Hours	No. Treated	No. of Failures	% of Cures
1	100,000	20,000	2	8	33	1	97%
2	100,000	25,000	3	9	21	2	90%
3	120,000	40,000	3	6	3	1	66%
4	150,000	50,000	3	6	40	4	90%
TOTALS					97	8	91.7%

Conclusions

These results of ambulatory treatment of sulfa-resistant gonorrhea by penicillin seem to justify its continued use. However, more investigation is necessary before the question of the optimum of the total dose and the time dose relationship is established. Perhaps experiments such as those of Romansky and Rittman⁷ producing prolonged blood-levels and slower excretion of the drug will result in a more simplified method of using penicillin in gonorrheal infections.

Van Slyke⁴ sounds a word of warning about the administration of penicillin in cases of gonorrhea which may mask the clinical and serological evidence of a concurrently acquired syphilis.

In closing, may I leave this thought. Paradoxically, penicillin, the great liquidator of the gonococcus, may by this very fact so remove the fear of promiscuous sexual adventure as to cause an increase in the venereal incident.

NOTE.—Since this article was written, several changes in the time-dosage schedule have been advocated. The author has had encouraging success in the use of 200,000 units of sodium penicillin intramuscularly in two doses at four-hour intervals.

The more recent use of the calcium salt orally will greatly simplify the method of administration of penicillin in Neisserian infections.

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Herniated Nucleus Pulposus

Protruded Intervertebral Discs

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IN 1934 Mixter and Barr⁵ reported 34 cases of protruded intervertebral disc that caused low back and sciatic pain. Isolated case reports appeared prior to this but the significance of this lesion in relation to the large group of individuals who have lame backs escaped recognition. Since 1934 operation for removal of protruded intervertebral discs has become a common procedure in neurosurgical clinics, and the literature dealing with this subject is voluminous. Some writers support the view that injury to the intervertebral disc is the most common cause of low back and sciatic pain and that operative removal of the disc is indicated in all cases. Others have a quite divergent view, feeling that disc lesions are often only incidental and their removal rarely required. Extreme examples of such opinions are found in recent papers by Dandy¹ and Magnuson.⁴ Their views are not supported by the experience of most surgeons. The army has required and industry will demand that more convincing data be brought forth to properly evaluate this disease in surgery.

This paper is based on a group of 280 cases of herniation of the nucleus pulposus upon which the writer has operated, 126 of whom were military personnel.

Anatomy.—The intervertebral disc is a fibrocartilaginous structure located between the bodies of contiguous vertebrae. It is composed of a

semi-fluid material, the nucleus pulposus, surrounded by a fibrous capsule, the annulus fibrosis. It acts as a semi-fluid medium between the vertebrae and has been described as a spinal shock absorber.³ It lends universal mobility to the spinal joints. At times as the result of unusual stress or strain or degenerative changes, the capsule of the disc ruptures and the nucleus pulposus herniates. The lesion may be found at any level of the spine, but the great majority occur in the lower lumbar area and cause low back and leg pain. The terms, herniated nucleus pulposus and protruded intervertebral disc describe identical lesions. There is difference of opinion as to involvement of the annulus fibrosis in the herniation. This gives rise to the two terms.

Herniation backward into the spinal canal will impinge upon neural elements and cause radiating radicular pain. Protrusion in other directions produces low back pain without radiation.

Etiology.—Back strain is the most common cause. Severe disability may follow one strain or come after many mild episodes of back pain. Many patients do not recall trauma, however. Degenerative changes in the capsule due to age, spinal arthritis, or other infectious diseases may predispose to rupture of the disc.

Symptoms and Signs of Lumbar Lesions.—The presenting complaint of lumbar lesions is low back and leg pain. The majority of patients will recall trauma and previous episodes of back pain that recurred frequently with effort. Many episodes of back pain may precede the development of leg pain. The pain is aggravated by motion of the spine and by coughing, sneezing, or straining. The patient is often more comfortable sitting than lying. Many prefer a hard bed and find it necessary to sleep on the side with the painful thigh flexed.

Numbness or tingling may be felt in the extremities. Occasionally motor weakness may be present. Inspection reveals scoliosis. Usually the tilt is away from the lesion. There is spasm of the lumbar muscles. Atrophy of the painful leg may be observed, and there may be demonstrable weakness of the calf muscles.

Flexion of the thigh with the leg straight produces pain. The same may be true with compression of the jugular veins or by pressure or percussion over the interlaminar space at the level of the lesion.

Read before the Fourth Annual Postgraduate Conference on War Medicine, the Seventy-Ninth Annual Session of the Michigan State Medical Society, Grand Rapids, Michigan, September 29, 1944.

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Careful sensory examination with pin prick and cotton wool will usually show sensory deficit in some part of the leg or foot. Anesthesia is never present. Tests for sensory loss should be carried out in comparison with the other extremity for changes are only relative. Tests that exaggerate or reproduce pain will increase sensory loss and may bring out sensory loss not otherwise detectable.

The ankle or knee jerk may be diminished or absent. Experienced examiners can often determine the presence and location of a lesion from clinical findings alone. In many cases lesions at the 5th interspace will show tenderness to percussion over the 5th spinous process and interspace between the 5th lumbar and the 1st sacral vertebra and will usually radiate pain into the leg and may reproduce tingling and numbness in the dorsum of the foot, sparing the great toe. Jugular compression will do the same. The ankle jerk is usually absent or diminished, the knee jerk normal. Lesions at the 4th lumbar interspace usually will produce sensory changes in the great toe and the knee jerk may be involved as well.

It is obvious, however, that the symptoms or signs just described are produced also by many other diseases. Contrary to recent publications, the differential diagnosis is not easy except in a few cases. Among the diseases from which it must be differentiated are (1) Marie-Strumpell arthritis, (2) Rheumatoid and osteo-arthritis, (3) Spinal cord tumors, (4) Developmental anomalies such as spondylolisthesis or spina bifida, (5) Destructive disease of the spine such as infections or neoplasms, and (6) Psychoneurosis.

X-ray Examination.—X-ray examination of the lumbo-sacral spine and pelvis is of profound value as a means of eliminating other disease. For the most part roentgenograms reveal no significant change. Recent claims that narrowing the joint space is demonstrable in most cases is not confirmed in our experience although careful attention has been given to this point.

Myelography.—The use of contrast media in the spinal subarachnoid space for fluoroscopic examination is a valuable diagnostic adjunct. The controversy which is raised about this procedure is interesting. Lipiodol had long been used for investigation of the spinal canal in the diagnosis of tumors and it was accepted by the profession as a justified and valuable procedure; however, when

its routine use was applied to the diagnosis of herniated nucleus pulposus many objections were raised, the most important being medico-legal. While we find it possible to operate on certain cases without contrast media, it is used in the majority. Numerous contrast media have been used. These include gases, lipiodol, iodochlorol, thoro-trast, and pantopaque. We have had experience with gas, with lipiodol, and with pantopaque. We now use the latter routinely as we find it more satisfactory from a diagnostic standpoint and more easily removed. In 1938 Hampton and Kubik² demonstrated that lipiodol could be removed from the spinal canal by simple aspiration. Due to a lower viscosity pantopaque is more easily and completely removed than lipiodol. Furthermore, it is absorbed gradually if left in place and no untoward complications have been reported when it is not removed.

Operation.—The operative procedure for the removal of a herniated nucleus pulposus, in experienced hands, is relatively free of risk. The operation may be done under general, spinal, or local anesthesia. A straight incision is made in the midline to extend the distance of two to three vertebrae. The muscles are detached from one side and retracted with a Hibbs' retractor. The ligamentum flavum between the laminae at the level involved is removed or opened and retracted, and the spinal canal entered. Many times it is possible to carry out this exploration without sacrificing bone. Rarely is it necessary to remove more than a few small bits. By retraction of the dura and the involved nerve root the lesion is exposed. It is overlaid by the posterior longitudinal ligament which is nicked, after which the protruded portion may be grasped with the pituitary rongeur and lifted out. The joint space should be entered with a scoop or pituitary rongeur and as much of the remaining soft tissue as is accessible removed. Usually from five to eight grams can be recovered. Caution must be exercised to avoid entering the abdomen when the joint space is being cleaned.

Troublesome bleeding may be encountered from the extradural plexus of veins but this can be controlled with pledgets of cotton during the operation and by muscle stamp grafts or fibrin foam thereafter. Closure of the wound is effected easily with three or four sutures of silk through the fascia and two layers of silk for the skin.

In approximately ten per cent of cases spinal fusion is considered necessary. Cases are selected for fusion if there is a spondylolisthesis or extensive arthritis of the joint space involved or if the facets at the level are poorly developed. Fusion is also carried out at times upon patients who have had recurrent or persistent symptoms following simple removal of the disc.

Postoperative Care.—Where simple removal of the disc has been done the patient is kept in bed for ten to fourteen days. For two days morphine may be necessary to control pain, and a few patients require catheterization for short periods. The patient's activities are limited to short walks for about two weeks after getting out of bed and usually after two to three months he is able to resume his activities as a laborer or soldier. In earlier cases we felt that all such patients could withstand full field duty and some have succeeded in doing so. The incidence of recurrent soreness of the back has been high enough, however, that the majority of patients are now sent back to restricted duties and under this program do satisfactorily.

Results.—Of the 126 military cases, 74 per cent have been returned to duty. It is impossible at this time to know how many have remained on duty or whether they have had recurrent complaints, but at the time of their discharge the majority regarded themselves as well. An additional ten per cent, making a total of 84 per cent, were much improved. An additional 8 per cent regarded themselves as improved and stated that the leg pain had disappeared, but were not sufficiently well to return to duty or to engage in their former civilian occupation. Four per cent of the patients had other diseases of their spine which required separation from the service. Removal of the disc in these was undertaken to improve symptoms. Four per cent state that they are no better or worse. Three wound infections occurred. Two of these were among the group who had residual complaints.

A few patients have complained of transient increased numbness of the foot after operation, but there have been no cases of motor weakness or paralysis. There has been no disturbance of urinary or rectal sphincter control. There have been no deaths.

It is believed by many that the joint from which

the disc is removed is ultimately fused and in cases who have been observed for long periods of time the joint space becomes progressively narrow, and evidences of hypertrophic traumatic arthritis are noted. There has not been sufficient follow-up among cases included in this paper to give an opinion as to the final result. It is believed, however, that some will return with recurrent backache after two to three years, and that they may require fusion.

Discussion.—From experience with this disease, certain points have become apparent. Many patients with injuries to the intervertebral discs will have episodes of pain from which they will recover with rest. These may remain well indefinitely. It is only when the herniating mass impinges upon a nerve root that operative removal of the disc is necessary. There is perhaps an occasional instance where backache due to torsion or stretching of the ligaments in the area from altered support may be benefited by removal of the disc. However, such an individual would usually recover spontaneously. If symptoms persist so that operation becomes necessary in such a case, fusion should be undertaken at the same time. Removal of a disc which is not herniated is not justified. Although careful attention has been given to the testing of mobility of a joint space at the operating table, we are unable to confirm Dandy's¹ observation that the mobility is notably increased. It is felt by this writer that the term "hidden disc" should be abandoned and that cases where no herniation is found should be listed as negative explorations. Fusion of the spine is necessary in about 10 per cent. Exaggeration of symptoms, particularly if the disc is an incidental part of an arthritic disease, occurs at times after operation. The operation as presently done does not exaggerate any instability of the spine that is present.

Conclusion

A large number of individuals who suffer with lame backs have protruded intervertebral discs as the basis of their complaint. If symptoms are protracted or if they have had frequent recurrences, operative removal of the disc is necessary. While relief following operation is remarkable, and the majority of patients can accomplish reasonable activity without symptoms, it is believed that few can withstand for any protracted

period the rigors of full military duty. If patients are instructed and permitted to avoid strenuous and fatiguing physical activity, the majority will remain well. The great majority of postoperative patients can accomplish vigorous activity for short periods without symptoms and without injury. Experience does not permit one to expect more of the operative procedure. No surgical or medical procedure, however, will cure every patient.

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MSMS

The Significance of Rectal Hemorrhage

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THE loss of blood, however slight, through the anal aperture is sufficiently alarming ordinarily to impel the host to seek medical consultation. Like the unheralded hemoptysis of incipient pulmonary tuberculosis, rectal bleeding is a beneficent development only when its numerous possible sources are explored and appropriate diagnostic procedures invoked.

It has been repeatedly stated by many distinguished clinicians that the particular duty of the

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consultant is to insert a finger into the patient's rectum. Without attempting to offer any explanation for this phenomenon of clinical apathy the fact remains that despite the exhortations of innumerable articles, it is still the careless custom of many physicians to ascribe rectal bleeding to hemorrhoids, often without any examination whatsoever. Other more conscientious practitioners, alive to the constant danger of overlooking a malignant neoplasm, would be hard-pressed nevertheless to entertain serious consideration of disorders other than hemorrhoids and carcinoma as possibly responsible for rectal bleeding.

In this discussion the causes of rectal bleeding will be considered for the express purpose of indicating the scope of the clinical vista which opens before the practitioner who is informed excitedly over the telephone or more calmly in his office that the patient is bleeding from his rectum. The excited telephone communication indicates almost uniformly that there has been a sudden and alarming blood loss. This in itself cannot be construed as the manifestation of an acute process because original massive rectal hemorrhage does occur in chronic diseases such as regional enteritis, and ulcerative colitis; and conversely, the bleeding associated with acute disease may be no more than a streak of blood on the toilet paper.

In the case of acute massive hemorrhage and particularly when the communication is telephonic it is most essential that the correct information be gained. At such times it does not matter who operated on him, or whether he was ever operated upon, the requirements will be identical. In order to obtain the essential information the doctor must formulate his questions carefully and accurately.

Ill-advised questions such as, "Is he bleeding very badly?" and "Has he lost much blood?" are prone to produce answers which cannot be evaluated and moreover may provoke alarm and excitement in the person with whom one is conversing. It is important to know when the bleeding started and whether or not there has been a bowel movement. By the reply to these queries the location of the bleeding can be deduced. If there has been no bowel movement one can be reasonably sure that the trouble is not in the rectum but in the anal canal or external. If it develops that the patient awoke from a sound

sleep with the desire to move his bowels and that when his bowels did move he passed much blood then the next logical and all-important question is, "Have his bowels moved again?" If they have moved one or more times with quantities of blood the physician will know that he must act quickly. Additional valuable information is gained by determining the time interval between evacuations. If the time interval between expulsions of these "blood enemas" is progressively growing shorter it is a serious situation and is the type of hemorrhage that occurs after surgery. If movements are occurring in periods of less than twenty minutes the case is distinctly urgent. Such a patient bleeding persistently into his rectum is in danger of his life.

The case that bleeds externally, usually following minor office surgery, is not in danger of his life but there is danger to the doctor's reputation.

In the consideration of rectal hemorrhage attributable to surgical procedures it is most important to recognize the injection treatment of hemorrhoids as a not uncommon cause. During the past six months I have seen five cases of profuse rectal hemorrhage following sclerotherapy elsewhere for hemorrhoids. One of these had a hemoglobin of 24 per cent and required three transfusions and another was transfused twice. It is important to note that all of these patients were, in my opinion, unsuitable for sclerotherapy, and surgical hemorrhoidectomy was later performed in four of the five cases.

Hemorrhoids, carcinoma, polyps, anal fissure and ulcerative disease of the mucous membrane are the most common causes of rectal bleeding. Internal hemorrhoids cannot be accurately diagnosed without an anoscopic examination.

All hemorrhoids, and more particularly newly developed hemorrhoids in older people, must never be accepted as purely local developments. It is of extreme importance to bear in mind that malignant disease of the upper rectum may in itself give rise to very few symptoms but by pressure cause hemorrhoids.

Portal obstruction, most often due to hepatic cirrhosis, is another major disorder in which troublesome bleeding piles may be an early complaint. There are two types of internal piles which cause bleeding. The first type consists of a large redundant hemorrhoidal ring usually showing marked prominence in the zones of the

three primary hemorrhoids, in the left lateral, right anterior and right posterior quadrants. This type shows a granular edematous redundant mucosa overlying the hemorrhoidal masses. Even in patients who have been bleeding freely with the bowel evacuations one can rarely demonstrate a bleeding source during proctoscopy because the redundant mucosa overrides the pin-point ulceration and moves freely over the underlying varices. In the second type of hemorrhoidal bleeding there is revealed during proctoscopy a very vascular purplish ring which bleeds readily just above the pectinate line. This type is more often observed in younger athletic individuals, particularly young women.

Rectal carcinoma causes bleeding in the later stages when ulceration has occurred. More often than not, in about 80 per cent of cases, the growth can be reached with the finger and sometimes a rectosigmoidal lesion can be palpated by examining the patient during straining in the squatting position. Rectal and colonic carcinoma should be suspected before gross bleeding has occurred. Outstanding symptoms such as change in bowel habit, nocturnal or early morning diarrhea, discharge of mucus or pus and in more advanced cases signs of partial obstruction indicate clearly the necessity for thorough investigation with sigmoidoscopic examination followed by roentgenological techniques.

All the papillomata and adenomata, whether sessile or pedunculated, congenital or acquired, are included under the gross anatomic term "polyp." They are frequent precursors of rectal and colonic cancer and should be destroyed. A single polyp may occur anywhere and is with submucous lipoma the most frequent cause of adult intussusception. Polyps of significant size located beyond the reach of the sigmoidoscope may usually be detected by means of a barium enema and double contract air-injection roentgenological technique.

Areas of hyperplasia of the bowel mucosa may bleed but are otherwise symptomless and are discovered only during proctoscopy. The symptoms of villous tumors or papillomas are much the same as of adenomas except that they are usually associated with the passage of mucus. Polyps of the colon and rectum should be radically destroyed or removed because of their tendency to malignant degeneration. Many can be handled

by fulguration and local removal but when necessary more radical surgery should be undertaken.

Single or multiple polyps producing rectal bleeding and associated symptoms are not uncommon in infants and children.⁸ In children the polyps are commonly attached to the bowel wall by a long slender pedicle which expands distally giving a club-like appearance. In a fifteen-year period forty-nine infants and children with rectal and colonic polyps were seen at the Mayo clinic. The chief symptoms were bleeding, abdominal distress, a mass prolapsing out of the anus and diarrhea. Less often the presence of mucus in the stools, painful or difficult defecation and spontaneous expulsion of a polyp were noted. Bleeding was intermittent and more than a teaspoonful of blood was never passed at one time. Blood was usually on the outside of the stool; i.e., not mixed with the feces. Abdominal pain was seldom severe and was most prominent in cases with polyps in parts of the colon other than the sigmoid or rectum. In each of the four cases in which proctoscopic examination was negative, roentgenography revealed a polyp in the colon.

The microscopic diagnosis in tissue obtained from eighteen of the forty-nine cases revealed eight benign adenomas, eight adenocarcinomas, grade one, one adenocarcinoma, grade two, and one reticulum-cell lymphosarcoma.

Familial polyposis intestini is an uncommon cause of rectal bleeding and causes a rapidly developing anemia. This lesion becomes active early in life. There is always a positive family history of either this condition or rectal or colon cancer. Examination or biopsy will demonstrate relatively normal mucous membrane between the individual polyps. On the other hand polyps secondary to chronic ulcerative colitis are separated by areas of the diseased mucous membrane characteristic of the primary condition. Even during remissions a swab applied to the mucosa will usually produce some bleeding.

At this point it may be well to emphasize the fact that probably the most common cause of small amounts of rectal bleeding in infants and children is anal fissure. The next most common cause is intussusception and the commonest cause of exsanguinating hemorrhage from the intestinal tract in infants and children is a bleeding Meckel's diverticulum.

In children, anal fissure is easily visualized without the use of instruments and with its sentinel skin tag, is readily recognized. The bleeding of intussusception is associated with passage of mucus and little or no stool. The blood is red but small in quantity and is passed after agonizing bouts of cramp-like pains associated with severe shock and often with the presence of a palpable tumor. Barium enema is confirmatory when the meniscus-like conformation is seen at the point of obstruction. Prolapse and procidentia which bleed because of extreme congestion and mucosal erosion may be of the internal or external varieties.

The term prolapse is used in connection with abnormal looseness, redundancy, and descent of the mucous membrane whereas procidentia designates an abnormal descent of all the coats of the rectum. While the external variety of either condition is readily recognized with the patient straining, the internal form may produce alarming and obscure symptoms. Blood-tinged mucus may be observed but the condition may evade detection if the patient is examined in the inverted position, when prolapse or procidentia are suspected.

Hemorrhage from a Meckel's diverticulum may be small in quantity and repeated, or large and even fatal. When blood loss is massive from the region of the infant's terminal ileum the stool will be reddish but not bright red and not tarry as is usually with Meckelian hemorrhage in adults. This color characteristic is distinctly valuable in diagnosis. It may be well to point out also that ulcerative colitis, regional enteritis, gastric and duodenal ulcer, and Bant's disease with bleeding esophageal varices have all been reported as having produced rectal bleeding in infants and children.

Since its debut as a clinical entity in 1932, regional enteritis has successfully resisted the search for a specific causative agent. Clinically, however, it is no longer an uncommon disease, and Fallis, among others, has recently reported a case, proved at operation, that presented a massive intestinal hemorrhage as the principal symptom.

Worms, usually the common pinworms (*oxyuris vermicularis*) may be responsible for bloody rectal spotting in children.

Hemorrhagic diatheses is a collective name for many diseases which in etiology and patho-

genesis are entirely different but which are characterized by purpura of the skin and bleeding from the mucous membranes. This type of bleeding is discovered commonly in the early years of life and must be considered in the differential diagnosis of rectal bleeding.

In adults fissure-in-ano is a common cause of blood-streaked stools and blood-stained toilet tissue. The fissure is commonly in the dorsal midline below the muco-cutaneous juncture. Severe pain, because of the rich sensory cerebrospinal nerve supply, and bleeding at stool are characteristic findings. In the late stages of evolution of this lesion a marked degree of anal stenosis is usually found, the result of spasm and fibrosis of the external sphincter muscle and its surrounding tissues. At this time the fissure is more properly described as an indurated anal ulcer and must be differentiated from epithelioma, chancre, chancroid, and tuberculous ulceration, all of which produce pain and bleeding.

Chancroid is sufficiently common to be considered in the differential diagnosis of any large ulcer. The typical lesions are multiple, the two commissures being favorite sites. The ulcers are ragged and undermined, induration is absent, a thin purulent discharge bathes the ulcer surface and the predominant symptoms are severe constant pain aggravated by the slightest touch.

Ulcerative lesions of the colon produce rectal bleeding with or without diarrhea, tenesmus and pus. Amebic enterocolitis, ulcerative colitis of the chronic type or of the fulminating thrombo-ulcerative variety, bacillary dysentery, tuberculosis of the ileocecum, colon, and rectum, and regional colitis must receive due consideration in this category. The differential diagnosis of the various types of colitis is clearly too extensive for adequate treatment in this paper. The careless habit of calling every case of bloody diarrhea ulcerative colitis is tragic in its consequences. Chronic poisoning, organic or inorganic, may produce bloody diarrhea. The diarrhea of gastric, or pancreatic achylia, if associated with bleeding anorectal lesions may also be a trap for the unwary. Similarly the diarrhea with psychic, endocrine, avitaminotic and allergic backgrounds may cause great confusion.

Amebic ulcerative colitis is an entity to be considered constantly. Its lesions are primarily in the cecum and flexures of the colon although the

entire large intestine may be involved. If the disease has progressed into the rectosigmoid and rectum the visualized lesions present a very characteristic appearance. The ulcers are of the umbilicated punched-out variety with raised edges covered by mucus and a hyperemic zone around each ulcer. Lynch has described the proctoscopic appearance of amebic ulceration as "smallpox of the mucosa." The intervening mucosa is relatively normal. Bleeding occurs rather late in amebic colitis and there should be little difficulty in distinguishing this type of ulcerative colitis from the streptococcal variety. Diagnosis is dependent upon clinical and roentgenological findings, on the discovery of the *Endamoeba histolytica* and upon response to treatment.

Chronic ulcerative colitis exhibits a changing proctoscopic appearance dependent on the stage of the disease. The early stage of general edema of the mucosa is followed by the formation of miliary abscesses and is succeeded rapidly by the miliary ulcers which produce miliary pock-like scars.

Tuberculous ulcers are larger characteristic ulcers with intervening normal mucosa.

Lymphogranuloma venereum is a clinical entity which can no longer be ignored in the differential diagnosis of procto-colitis.

The diagnosis of the genito-anorectal syndrome of lymphogranuloma venereum is simple if its possibility is considered. Unfortunately the impression is prevalent that it is a disease of prostitutes, particularly negroes, and their clientele. On the contrary, like all other venereal diseases, it is widely disseminated throughout the United States and is encountered in whites frequently. The most characteristic lesion is the unilateral or bilateral suppurating or nonsuppurating inguinal bubo. A positive history of the practice of pederasty is most important in diagnosis. Confirmation of clinical impression is by means of the Frei intracutaneous test, the serum neutralization test, the demonstration of the virus by animal inoculation, and by complement fixation. In this condition there is a period following the primary inoculation with the virus during which proctitis alone is in evidence and a bloody purulent discharge exudes from the granulation surface replacing the normal mucous membrane. Since sulfonamide drugs are of outstanding value in the early stages of lymphogranuloma venereum

it is exceedingly important that the diagnosis be made early before irreversible structural changes in the bowel have occurred.

It has been stated that rectal stricture not due to the trauma of hemorrhoidectomy is the ultimate result of rectal lymphogranuloma venereum.

The virus, which has been isolated from the rectal mucosa, as long as twenty-one years after the original bubo, produces an almost pathognomonic type of rectal stricture. It is the result of an inflammatory and cicatricial infiltration of the entire rectal circumference. Rubberlike in consistency and superficially markedly granular, it grasps the exploring finger snugly like a glove.

Whereas the one-time greatly overestimated incidence of gonorrheal and syphilitic strictures of the rectum must, in effect, be excessively rare, syphilitic proctitis with structural changes has been reported and must be considered in differential diagnosis.

Simple hemorrhagic proctitis and proctosigmoiditis is rectoscopically, microscopically and clinically characteristic. The mucosa in this condition is bright red, moist and glistening and finely granulated. Hyperemia and hemorrhages in the tissue stamp the microscopic picture. The graver cases seem often to start with a mild proctitis as the only symptom and may maintain this stage for years until a sudden exacerbation of the inflammation, and possibly into the sigmoid flexure causes advancing symptoms.

Coloproctitis, hemorrhagic in type, may occur in uremia, in fulminant cases of diabetes mellitus, typhoid, septicemia, puerperal sepsis, severe marasmus and in certain types of avitaminosis.

The old dictum that "Gonorrhea is a disease one sees if one looks for it," applies particularly to rectal gonorrhea, for the symptoms are frequently mild or entirely missing. The most common symptom is rectal soreness occurring after 3 weeks following the onset of the genital infection. Gonococcic proctitis usually remains localized to an area just above the pectinate line and is an infrequent cause of scanty rectal bloody staining. However, rectal gonorrhea is certainly much more common than its diagnosis and its incidence in women who had suffered genital infection has been reported as ranging from 15 to 85 per cent. In the male, anorectal gonorrhea is a rare disease. The complications of anorectal gonorrhea, stricture, abscess, fistula, condylomata and polypoid rectal excrescences can

in their own right be responsible for mild rectal bleeding.

Factitial or radiation proctitis is usually observed in women who have sustained intensive radiotherapy for disease of the cervix or body of the uterus. The pathologic changes may be grouped into three stages: congestion or hyperemia is noted in the incipient cases; in the second stage telangiectases that bleed at the slightest touch make their appearance. As the lesion progresses ulceration occurs usually as a single oval ulcer involving all layers of the rectal wall with a smooth margin and a slimy greenish gray slough covering the base of the crater. Although marked improvement is seen the telangiectases persist for years. The third stage is stricture or organized narrowing of the rectal lumen. Bleeding is invariably the most common symptom and is usually associated with defecation. It may be bright red drops, dark clots or streaks on the stool. In rare cases profuse hemorrhage has been reported. Such symptoms as tenesmus, frequent and urgent desire for stool, incomplete evacuations and fecal discharges mixed with mucus, pus, blood and necrotic material are cited in cases where stricture has supervened. With a history of interstitial uterine irradiation and the presence of a pearly white plaque situated on the anterior rectal wall there is little difficulty in making a diagnosis of radiation proctitis. However, when the rectal lumen is entirely encircled by this process it is often no easy matter to decide whether it is the result of radiotherapy or an extension of the malignancy.

In cases in which malignant change has extended to the rectum there is no typical membrane and the constriction is irregular and nodular in contrast to the more even distribution of the fibrosis resulting from irradiation.

Repeated negative biopsies from different portions of the stricture are the only means of ruling out malignant extension.

Foreign bodies and trauma are important causes of rectal bleeding and are usually readily diagnosed.

Anal stenosis is not uncommon and is productive of much abdominal and pelvic distress. As a source of pain and bleeding it frequently remains unrecognized. Anal narrowing is the result of fibrotic changes in the pecten region of the external sphincter where it occupies approx-

imately the middle third of the anal canal and is evidenced as a hard band of fibrous tissue. Large bulky stools will cause tears in the anal canal with bleeding. A tight uncomfortable anal canal which offers resistance to simple digital examination must therefore be suspected as a source of rectal bleeding.

Fecal impaction might well serve as the title of an interesting paper indicating the extent to which this development has been clinically overlooked. As a possible source of bleeding it is distinctly worthy of careful consideration. It has been known to exist in an incomplete form for many months without its presence being suspected. The host may believe that his bowel evacuations are normal. Liquid or semi-formed stools are forced past, alongside and around the obstructing fecal column. Rarely, canalization through the inspissated mass will take place. In the badly obstructed case there may be a constant desire to go to stool especially when standing. The advancing fecal column with its head obstructed either at the rectosigmoid or uncommonly at the anorectal junction, due to forcible peristalsis produces considerable trauma to the mucosa of the bowel and when low down, to the very vascular hemorrhoidal area. This condition must be differentiated from carcinoma and anal fissure.

Diverticulosis of the colon does not produce bleeding. Diverticulitis does produce blood, free or mixed with feces in about 20 per cent of cases according to Hayden. Diverticulitis is a common finding in sections of the colon resected for proven carcinoma and therefore the possibility of a co-existing carcinoma must be ruled out before the diagnosis of diverticulitis is permitted to obtain.

The importance of endometriosis as a cause of constricting lesions of the rectum and sigmoid colon has been greatly underestimated. Such lesions can easily be regarded as carcinomatous and the patients subjected to radical bowel resection instead of the ordinarily sufficient operation of castration.

A digest of figures from reliable sources discloses that approximately 15 per cent of all women develop endometriosis and that 25 per cent of all women with pelvic endometriosis have lesions of the rectosigmoid which leaves us with the significant figure of 2 to 4 per cent of all women, at some time during their active men-

strual life, having endometriosis of the sigmoid, rectum or rectovaginal septum.

The most frequent complaint of patients with obstructive symptoms is severe progressive constipation usually associated with low abdominal pain distinctly aggravated at menstruation. Sigmoidoscopic examination may reveal narrowing of the bowel lumen with intact but puckered and congested mucous membrane. The mucosa is rarely sufficiently involved or ulcerated to permit biopsy. The intact mucosa explains the low incidence of rectal bleeding traceable to endometriosis of the rectosigmoid which is included here primarily because of its ready confusion with carcinoma. The Mayo clinic has reported rectal bleeding from rectosigmoidal endometriosis discovered after and presumed to have been produced by uterine suspension operations.

Vicarious menstruation is a rare cause of rectal bleeding. That it cannot be ignored is attested to by the fact that I saw during August, 1944, an otherwise healthy sixteen-year-old high school girl who has been experiencing fresh rectal bleeding every month for the past six months. Abdominal, vaginal, full-length sigmoidoscopic and barium enema examination failed to reveal a cause for the bleeding.

Conclusion

This presentation of significant clinical observations possessing the common symptom, rectal bleeding, is offered for the purpose of renewing attention to the terminal portion of the intestinal canal and to emphasize that it is the site of numerous disorders, of local and general importance, and that these variegated disturbances must be considered in any investigation of the alimentary tract.

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\$100,000 in Fifty-two Weeks



During the war years the training of young men and women for the practice of medicine has reached such a low ebb that replacements have nearly approached the zero point, and the streamlining of courses to adapt the student to war work did not necessarily suffice for practice in civilian life. On their return from military duty there will be need for postwar graduate study and many civilian doctors likewise will want refresher courses, and some will wish training sufficient to make them eligible for specialty boards.

Looking well into the future needs of health education, the late Andrew P. Biddle, M.D., and his wife, originated a plan for the permanent financing of proper training which has been followed up by a committee of the State Society; and now there has been organized the Michigan Foundation for Medical and Health Education. The retiring president, Andrew S. Brunk, M.D., has contributed generously to this fund, leading the way for others to do likewise. At the present time, some \$33,000 have been added to the Biddle gift. The goal is \$100,000 or more in the next year. Let us hope the drive succeeds, and I believe it will for surely there are many individuals and County Societies who will want to contribute to this worthy cause.

President's



Page

A. Morrish

President, Michigan State Medical Society



Editorial

THE EIGHTIETH ANNUAL SESSION

WARTIME REGULATIONS canceled the meeting of the Michigan State Medical Society at the announced time for the Eightieth Annual Session. There was, however, an historic meeting of the House of Delegates and of the Council, the administrative and governing bodies of the society. Several outstanding actions were taken looking to the improved administration of medical care, the improvement of the quality of medical care and the improvement of the relations between the profession and the people.

First, a new statement of position with regard to the caring for wards of the government, and in anticipation of the time when we may all willy-nilly be wards of the government. It is the opinion of the Council, approved by the House of Delegates, that wards of the government are not indigent, the government—their “foster parent”—is not indigent.

Second, medical and health (postgraduate) education are prime motives of the Society, have been advocated and sponsored by the Society over a long period of years, and are now set up in a formal Foundation which already is growing in popularity, and sets a precedent for further good works.

Third, the House of Delegates approved the work of the Drafting Committee setting up a group of principles that the profession will support when made the basis of national legislation amending the Social Security Acts.

Fourth, the House of Delegates provided for the extension of Public Relations and advancement of medical programs for better education in regard to all matters vital to good medical standards, facilities, and organization, by spreading a special assessment on all members of \$25.00 in addition to the regular dues of twelve dollars per year. The dues and assessments for 1946 for the State Medical Society will be \$37.00 in addition to the County Society dues.

This House of Delegates has placed itself far in the lead of Medical Organizations and is to be congratulated on its foresight.

GOVERNMENT WARDS NOT INDIGENT

THE HOUSE of Delegates took action that will have far-reaching effects, and may be the pointing of a further means of preserving independent American Medicine. Last February the Executive Committee of the Council formally renounced the understanding into which the profession had been lead years ago when co-operating with agencies of government in caring for the indigent to the extent of doing the work for cost or less. This was during the years of the great depression.

Throughout the years since then it has developed that government through its bureaus has recognized its responsibility for care of the indigent, and has with one exception paid for the materials and services demanded. The grocer, the clothier, the landlord, have been paid, but the doctor of medicine is expected to do his work for cost or less. We have been too altruistic and too sympathetic during the ages, and have been exploited for that reason, plus the reason that some of us have been afraid of each other, and many have been willing to underbid the other fellow in order to see that he does not get the work.

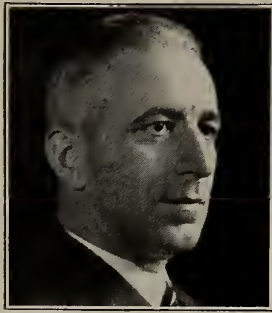
Unfortunately that spirit has grown in our individualistic endeavors. Appreciating that this situation is being relegated to the limbo of forgotten things, and wishing to gain a favorable position in the struggle that is sure to come when depression again menaces, the Council announced the principle that medical services are commodities worthy of their cost, and that while we are still willing and ready as individuals to render our charity to those whom we choose to consider worthy, we firmly contend that government wards are not indigent. As soon as people become wards of the government they are the responsibility of the richest personage or organization on earth, who has always recognized its responsibility to pay the price for the things bought from the butcher, the baker, the clothier. We think it now time to assert our own worthiness. To that end a Committee was appointed to study the subject

(Continued on Page 1218)

MSMS Officers—Elected 1945



Wm. A. Hyland, M.D.
Grand Rapids
President-Elect



P. L. Ledwidge, M.D.
Detroit
Speaker



John S. DeTar, M.D.
Milan
Vice Speaker



E. F. Sladek, M.D.
Traverse City
Councilor, 9th Dist.
Chairman, Council



O. O. Beck, M.D.
Birmingham
Councilor, 15th Dist.
Vice Chairman, Council



R. S. Morrish, M.D.
Flint
President



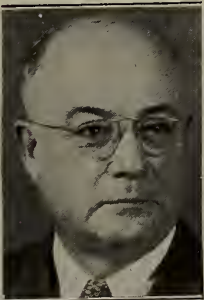
E. R. Witwer, M.D.
Detroit
Councilor, 16th Dist.
Chairman, Finance
Committee



P. A. Riley, M.D.
Jackson
Councilor, 2nd Dist.



R. C. Pochert, M.D.
Owosso
Councilor, 6th Dist.



Wilfrid Haughey, M.D.
Battle Creek
Councilor, 3rd Dist.



O. D. Stryker, M.D.
Fremont
Chairman, County
Societies Committee



F. H. Drummond, M.D.
Kawkawlin
Chairman, Publication
Committee



A. S. Brunk, M.D.
Detroit
Treasurer, MSMS

of payment for medical services by government agencies.

The Committee whose chairman is Robert L. Novy, M.D.,* made its report and suggested a schedule of *minimum* fees at the Session of the House of Delegates. The Committee's labor was monumental, representing the study and compilation of 121 Fee Schedules from all over Michigan, and including the Veterans Bureau and other government lists. Over 26,000 items were condensed into about five hundred. The committee gave what they considered a fair minimum schedule, and while the whole is definite and acceptable, there are always some items that do not suit everyone, or about which there may be justifiable differences. The Schedule and the Committee report was studied at length, by the House and by the reference committee, a whole night being given by the latter. In adopting the report, the suggestion of the Committee to allow thirty days for suggestions and adjustment of rates was adopted. Copies of the report were sent to all County Society Secretaries to allow study and submission of suggestions.

The Medical Profession of Michigan has again asserted its leadership in matters of medical public interest by propounding a program that will help solve our problems of regimented medicine. We have the plan, and the announced determination to demand reasonable compensation for our services rendered to those whose sponsors can and should assume their natural responsibilities. All we must now do is to work together. We are asking nothing unreasonable. We are not setting up fees for our members like so many bureaucracies have done, a top fee to be paid only if they must. We have outlined what we consider a reasonable *minimum schedule*, which our doctors may increase at any time they believe it is reasonable to do so.

These schedules we believe are fair to the doctors of medicine who render the services, to the officials responsible for providing medical care to the government wards, and are necessary to the welfare of the people if we are to give them the very best of medical service. We now have an anchor to which we must cling if we are to stave off encroachments that are threatening on *every side*. *In Unity There is Strength*.

*Members of the Committee: R. L. Novy, M.D., Detroit, Chairman; A. B. Smith, M.D., Grand Rapids; C. E. Toshack, M.D., Saginaw; Frank Van Schoick, M.D., Jackson; E. R. Witwer, M.D., Detroit.

POSTGRADUATE EDUCATION

A SECOND ACCOMPLISHMENT of the Eightieth Annual Session is the establishment and incorporation of the "Michigan Foundation for Medical and Health Education." Fifteen years ago organized efforts to bring postgraduate medical education to the doctor in his home were started and have been so successful that in Michigan alone of all the states a stupendous work has been accomplished. This last year 55 per cent of the doctors in Michigan were enrolled in home courses of postgraduate education. If we are to keep abreast of the fast advancing medical knowledge and are to give our patients the very best of skill, and the benefit of the most advanced research, we must attend meetings and courses where this information is analyzed, digested and evaluated for us. That Michigan has done, and is doing. But the efforts are not yet sufficient.

Attempts have been made to establish a fund to extend and carry on this work, with varying success. This year we have established our Foundation on a more suitable ground, and made it much more attractive. The Presidential Address of A. S. Brunk, M.D., published last month announced a goodly number of contributions to the Foundation, and set up a goal of one hundred thousand dollars new donations, to be reached within twelve months. He reported and listed eleven names the day he read his address. There have been others added since, who will be announced from time to time by the Board of Trustees.

MICHIGAN MEDICAL SERVICE GIVES \$10,000

MICHIGAN MEDICAL SERVICE at the annual meeting of its Board of Directors October 3, 1945 again fulfilled its objective. It voted unanimously a contribution of ten thousand dollars (\$10,000) to the newly established Michigan Foundation for Medical and Health Education. Part of the enabling act under which the plan is operating provides that it shall promote education in medicine and health for the benefit of its certificate holders, and to ensure the best of medical care. This provision is also in the By-Laws. Until now the Michigan Medical Service has devoted itself to perfecting itself, and gaining financial stability. Now for the first time an oppor-

tunity affords to promote medical and health education in a substantial manner, and according to the ideals held at the inception of the Service.

Again Michigan Medical Service leads the way, and we offer heartiest thanks and felicitations.

NATIONAL SOCIAL SECURITY

IN THE YOUTH of our country the American people were independent. And they spelled that word with Capital Letters. They believed in supplying their own wants and doing it by their individual efforts. We established our independence as a nation because we did not wish to be told what we could do, and whose tea we could drink.

During the time of our growth and maturity we kept to that theory of life and produced in this country the best brains the world has seen. We invented new things when the world developed so far as to demonstrate a need. We planned, and produced, and made our people great, but we also made some of them soft.

In this development we have advanced the scope and responsibility of medicine from a helter skelter educational lack of standard in which almost anyone could claim to be a doctor, to a position of unexcelled educational facilities and requirements, to a position of rendering modern and skillful, but somewhat more expensive medical services. Some of our people and many of our social minded workers have encouraged a dependence in multitudes of the people, so that now they are asking for security, not for the chance to produce their own security. This leads politicians and bureaucrats to foster schemes of painless giving to those of the people who are asking for the easy way out. We have had a multitude of such legislation offered, the sponsors of all of which claimed to have sought and secured medical advice in setting up their programs.

They never have sought the aid of the men and organizations which by their very nature are best qualified to advise. It has therefore become necessary for our representative medical organizations and men to meet this situation. Also certain of our legislators have suggested the advisability of some concerted effort to formulate plans that the profession could and would support if given a chance. Michigan through its Council and its Drafting Committee has proposed certain principles. Other states have followed suit, and

the American Medical Association has promulgated its Fourteen Points.

Sufficient facts have been accumulated, and a joint session of these various committees and Councils should now be held to propose a National program, an amendment to the Social Security Act that will supplant the Wagner, Murray, Dingell atrocity, and the new Pepper National Maternity service bill recently introduced and advertised as offering Maternal services to all women of whatever position of wealth, all free. Such a medically sponsored act would also render unnecessary the various proposals that have been introduced in the state legislatures, and are proposed for early 1947.

No time should be lost if some reasonable and well guided legislation is to be secured. And the Congress would in our opinion welcome a program advocated by the men and organizations most able to carry on and guarantee the functioning of the Act.

MEDICAL READJUSTMENT

DURING THE WAR we have had 2,287 medical men from Michigan in the armed forces. Many of them have been extremely busy, not always in medical or surgical work, and most of them feel the need of refresher courses before returning to the private practice of medicine. As individuals they recognize some weaknesses and wish opportunities to make readjustments. It is a major ambition of the profession to supply this need. (This condition incidentally does not mean there is no such need among those who stayed at home and worked.) The House of Delegates at the Eightieth Annual Session unanimously took action to aid in meeting this demand, and others that stare us in the face. It also recognized the need for better public relations.

Every crack-brained scheme for the control of the practice of medicine has been able to get publicity, and the public in general has been led to believe and believes (wrongfully we know) that the medical profession is not all true blue. (Read again the report of Mr. John Hunt's survey in Michigan.)* National magazines flatter us editorially and blast us by their staff writers in articles which can be nothing but inspired from certain sources. (See *Collier's* Editorial quoted

(Continued on Page 1269)

**Jour. MSMS* November, 1943.

PROCEEDINGS OF THE MSMS HOUSE OF DELEGATES — 1945

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MICHIGAN STATE MEDICAL SOCIETY

Eightieth Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

Book-Cadillac Hotel, Detroit, Michigan

Monday Evening Session

September 17, 1945

The first meeting of the Eightieth Annual Session of the House of Delegates of the Michigan State Medical Society convened in the Crystal Ballroom, Book-Cadillac Hotel, Detroit, Michigan, at eight-thirty o'clock, P. M. P. L. Ledwidge, M.D., of Wayne County, the Speaker, presiding.

THE SPEAKER: The House will please come to order. Is the Credentials Committee ready to report?

I. Record of Attendance

COUNTY	DELEGATE	MEETING		
		1st	2nd	3rd
1. Allegan	W. C. Medill	x	x	x
2. Alpena-Alcona-Presque Isle	F. J. O'Donnell	x	x	x
3. Barry	C. A. E. Lund	x	x	x
4. Bay-Arenac-Iosco	C. L. Hess	x	x	-
	R. C. Perkins	x	x	x
	D. W. Thorup	x	x	x
5. Berrien	R. L. Wade	x	x	x
6. Branch	A. T. Hafford	x	x	x
7. Calhoun	B. G. Holtom	x	x	x
8. Cass	S. L. Loupee	x	x	-
9. Chippewa-Mackinac	B. T. Montgomery	x	x	x
10. Clinton	W. B. McWilliams	x	x	x
11. Delta-Schoolcraft	A. H. Miller	x	x	x
12. Dickinson-Iron	D. R. Smith	x	x	x
13. Eaton	P. H. Engle	x	x	x
14. Genesee	Henry Cook	x	x	x
	A. H. Kretchmar	x	x	x
	Alvin Thompson	x	x	x
	J. H. Curtin	x	x	x
	D. C. Eisele	Not	Repres'd.	
15. Gogebic				
16. Grand Traverse-Leelanau-Benzie	R. T. Lossman	Not	Repres'd.	
17. Gratiot-Isabella-Clare	M. G. Becker	x	x	x
18. Hillsdale	L. W. Day	x	x	x
19. Houghton-Baraga-Keweenaw	H. J. Winkler	Not	Repres'd.	
20. Huron	C. W. Oakes	x	x	x
21. Ingham	C. F. DeVries	x	x	x
	L. G. Christian	x	x	-
	R. S. Breakey	x	x	x
22. Ionia-Montcalm	W. L. Bird	x	x	x
23. Jackson	J. J. O'Meara	x	x	x
	C. S. Clarke	x	x	x
24. Kalamazoo	L. W. Gerstner	x	x	x
	R. J. Armstrong	x	x	x
25. Kent	R. H. Denham	x	x	-
	L. E. Sevey	x	x	x
	A. V. Wenger	x	x	x
	W. B. Mitchell	x	x	x
	Harry Lieffers	x	x	x
26. Lapeer	D. J. O'Brien	x	x	x
27. Lenawee	E. T. Morden	x	x	x
28. Livingston	H. L. Sigler	x	x	x
29. Luce	H. E. Perry	Not	Repres'd.	
30. Macomb	W. A. Sibrans	Not	Repres'd.	
31. Manistee	E. A. Oakes	x	x	x
32. Marquette-Alger	R. A. Burke	Not	Repres'd.	
33. Mason	C. A. Paukstis	x	x	x
34. Mecosta-Osceola-Lake	P. B. Kilmer	x	x	-
35. Medical Society of No. Central Counties	R. C. Peckham	x	x	x
36. Menominee	F. J. Dewane	x	x	x
37. Midland	Harold H. Gay	x	x	x
38. Monroe	T. A. McDonald	x	-	-
39. Muskegon	H. D. Dykhuisen	x	x	x
	L. E. Holly	x	x	x
40. Newago	J. W. O'Neill	x	x	x

41. Northern Michigan	G. H. Wood	x	x	x
42. Oakland	R. H. Baker	x	x	x
	P. E. Sutton	x	x	x
	J. S. Lambie	x	x	x
43. Oceana	Wm. Heard	Not	Repres'd.	
44. Ontonagon	H. B. Hogue	x	x	x
45. Ottawa	C. V. Costello	x	x	x
46. Saginaw	L. C. Harvie	x	x	x
	A. J. Cortopassi	x	x	x
47. Sanilac	R. K. Hart	Not	Repres'd.	
48. Shiawassee	C. L. Weston	x	x	x
49. St. Clair	George Waters	x	x	x
50. St. Joseph	R. A. Springer	x	x	x
51. Tuscola	H. T. Donahue	x	x	x
52. Van Buren	W. R. Young	x	x	x
53. Washtenaw	H. H. Riecker	x	x	x
	R. N. DeJong	x	x	-
	J. S. DeTar	x	x	-
	H. P. Lynn	x	x	x
54. Wayne	W. D. Barrett	x	x	-
	R. L. Novy	x	x	-
	L. W. Hull	x	x	-
	S. W. Insley	x	x	x
	T. K. Gruber	x	x	x
	W. B. Harm	x	x	x
	H. A. Luce	x	x	-
	W. S. Reveno	x	x	-
	W. B. Cooksey	-	x	x
	R. H. Pino	x	x	-
	A. E. Catherwood	x	x	-
	J. M. Robb	x	x	x
	G. L. McClellan	x	x	x
	M. A. Darling	x	x	-
	C. F. Brunk	x	x	x
	W. W. Babcock	x	x	-
	H. F. Dibble	x	x	x
	F. G. Buesser	x	-	x
	C. K. Hasley	x	x	x
	Arch Walls	x	x	-
	Volney Butler	x	x	x
	R. V. Walker	x	x	x
	W. J. Stapleton, Jr.	x	x	-
	R. A. Johnson	x	x	x
	R. M. Athay	x	x	-
	T. G. Amos	x	x	x
	E. G. Krieg	x	x	x
	J. H. Andries	x	-	-
	H. W. Plaggemeyer	x	-	-
	J. J. Lightbody	x	x	-
	L. J. Morand	x	-	-
	B. H. Douglas	x	x	x
	J. K. Bell	x	x	x
	Harry L. Clark	x	x	x
	J. A. Kasper	x	x	-
	J. E. Cole	x	x	x
	W. F. Seeley	x	x	x
	H. L. Morris	x	x	x
	F. A. Weiser	x	x	-
	W. L. Brosius	x	x	x
	C. L. Candler	x	x	-
	L. T. Henderson	x	x	x
55. Wexford	W. Joe Smith	x	x	x
56. Speaker	P. L. Ledwidge	x	x	x
57. Secretary	L. F. Foster	x	x	x
58. Immediate Past President	C. R. Keyport	x	x	x

J. J. O'MEARA, M.D.: Mr. Speaker, I hold in my hand the credentials of eighty-six elected delegates to the Michigan State Medical Society, representing over 40 per cent of all delegates.

THE SPEAKER: If there is no objection from the House, the Chair will accept the report as a roll call.

The first order of business is the appointment of committees. We will first appoint the Press Committee. It will be as follows:

H. F. Dibble, M.D., *Chairman*
E. A. Oakes, M.D.
L. Fernald Foster, M.D.

We are glad at this time to welcome the press once more, and we ask of them the same courtesies they have shown us in previous years. They have been very, very kind, and we appreciate it. This year, as before, that courtesy can only be manifested by publishing nothing except that which passes through our Press Committee. They will give you everything that can possibly be put out.

PROCEEDINGS OF HOUSE OF DELEGATES

The Reference Committees will stand as they are on pages 5 and 6 in your Handbook, with these exceptions. On the Reports of Special Committees, Dr. G. L. McClellan will be replaced by Dr. Ralph H. Pino as chairman. On the next page, on the Reference Committee on Resolutions, Dr. A. C. Pfeiffer of Genesee County, who is not here, will be replaced by Dr. J. H. Curtin, also of Genesee County.

I am sure that the House is glad to welcome our old friend, Ed Spalding, now Colonel Spalding, and we shall take a little bow from him, and if he cares to make any remarks, we shall be glad to hear him.

COLONEL SPALDING: This is the only time I didn't think I could be heard from the back row.

THE SPEAKER: There are a few announcements to be made. During the meeting you will be handed an envelope, with some printed material in it, if you haven't it already. That contains some documents that are quite important for you at this time, among other things, two of the very important resolutions that will be brought before the House, so that you may have an opportunity to study them before they come up for vote.

I might announce at this time, and I shall also announce it later, that the Reference Committee on Resolutions will have a meeting tomorrow morning at 8:45, from 8:45 to 10:00, for the purpose of hearing suggestions and complaints on the resolution that will have to do with the adoption of uniform fee schedules. That will be in Parlor K. Study the resolution, and if you have any suggestions or criticisms to make, appear there tomorrow morning.

There is another very special announcement, and that is with regard to the program that has been prepared for the Conference on Rheumatic Fever. That will begin in this room Wednesday morning at 9:30. There is excellent talent on the program, both from out of the state and from our own group, and we hope you will have a lot of interest.

The only other matter has to do with the Reference Committees. The Reference Committees will meet in the places designated in your Handbook. The stenographers to take notes for the Reference Committees will be in Parlor D. They will be there continuously. Please do not ask them to go elsewhere to take notes. They are there to serve you all and will give you good service if you bring your work there.

The next item of business is the Speaker's Address. I shall ask Vice Speaker E. A. Oakes to take the chair.

(The Vice Speaker took the chair.)
THE VICE SPEAKER: Mr. Speaker, I would like to say a word, first. Some of you may be new in the House of Delegates. Most of your faces are familiar. It is always customary to open this session with an address by the Speaker of the House. The Speaker will outline to you the things that you will be most concerned with in this meeting. Your close attention is not only desirable, but it is invited, so that you may more knowingly conduct the business of this House.

I would like to introduce to you at this time, P. L. Ledwidge, M.D., of Detroit, Speaker of the House of Delegates. (Applause)

II. Speaker's Address

In his address to the 1943 House of Delegates your Speaker discussed the EMIC program, and emphasized the inherent danger in the precedent which that program established; the precedent of caring for nonindigent, private patients for fees set and paid by the Federal Government. It was made clear that the Doctors of Medicine in Michigan were in favor of generous monetary allotments to our fighting men by the following statement: "The United States has the money and the obligation to pay its enlisted men sufficient income to amply provide their dependents with food, clothing, shelter, medical care and other necessities." We felt, however, that to provide for everything else by allotment, and without restriction as to spending, and to single out medical care for direct payment at a set fee was both unnecessary and discriminatory.

To the 1944 House of Delegates we gave a progress report on the EMIC program, mentioning its rapid growth, the tremendous sums of money involved—\$42,800,000—having been appropriated for one year, and calling attention to the very aggressive and sometimes arbitrary manner in which it was being administered by the Federal Children's Bureau. It was pointed out that, while the EMIC program is limited by Congressional Act to the duration of the war plus six months, we must expect and be prepared to meet further legislation along similar lines. That this was a timely warning has been abundantly proven by subsequent events.

Doctor H. H. Skinner of Yakima, Washington, has beautifully summarized some of these events as follows: "The Children's Bureau was directed by Congress to establish the EMIC Program for preservation of the soldier's morale. The Bureau seized the opportunity to

regiment the soldiers' wives and the physicians of the United States by definite moves toward socialized Medical Health Centers.

Consider the following—step by step.

1. Bureau experiments with the EMIC Program to establish a precedent.
2. Bureau controls and administers entire medical and surgical care for every wife eligible for the EMIC Program.
3. Bureau plans definitely to extend and expand the EMIC Program into postwar time. (*JAMA*, 3/3/45—P. 530 #2.)
4. Bureau proposes care of all maternity cases throughout the country—with plans for hospitals, and proposes transportation beginning with pre-matures. (*Parents Magazine*—Jan., '44, and *JAMA*—Page 530, last paragraph. Page 531, 1st and 2nd paragraphs.)
5. Bureau proposes to control ALL Children's Health by:
 - (a) Urging free care for ALL children of all ages (*JAMA*, 3/45, P. 530, para. 3, #3, 2nd column.)
 - (b) Assuming care of and making government wards of all crippled children. (*JAMA*, Page 531, #5.)
 - (c) Working for the ELIMINATION OF COURT ACTION in determining children's eligibility for an all-inclusive bureau care (same as b)
 - (d) Directives for child guidance and education. (P. 531, para. 4-5 and #6 g.)
 - (e) Administering complete dental care to EVERY CHILD IN U. S. (Professional Barriers must be broken down.) (*News Release*, Children's Bureau 3/1/45.)
 - (f) The assuming of complete pediatric practice through Health Centers controlled by the Bureau. (P. 530, #3.)
6. Circulars, directives, committee minutes, magazine Bureau statements are all PROOF of the obvious movement to establish political medicine.
7. The Bureau is "guided" by Bureau-appointed "Steering" committees, and by "advisory" committees, also appointed, convened, and controlled by the same Bureau.
8. No recognition has ever been extended to State Medical Associations, the members of which must carry on the Children's Bureau Program."

On July 26, 1945, the following statement was released to the public press from Room 10-B, Senate Office Building, Washington, D. C.:

"A ten-year program of expanded Federal-State Maternal and Child Health Services available to all mothers and children who wish to use them, was proposed in a bill introduced in the United States Senate today by Senator Claude Pepper and nine other Senators.

"The bill which authorizes the appropriation of \$100,000,000 for the first year, would provide complete maternity care, including prenatal and postnatal service, to all mothers who elect to participate in the benefits of the programs. It would also provide preventive, curative and corrective services for children in the home, clinic, and school, and would expand medical programs for crippled and other physically handicapped children, as well as welfare programs designed to curb child delinquency. The Federal Administrative Agency would be the Children's Bureau of the Department of Labor."

From the foregoing, several things seem evident:

1. There is a public demand for some changes in methods of distribution of medical care and for health legislation. This demand is being promoted and stimulated by the Federal Children's Bureau.

2. The Congress is anxious to pass Health Bills that will satisfy the public.

3. The members of Congress are being largely guided, or in the opinion of some of us misguided, in their thinking by the Federal Children's Bureau.

This proposal of "The Pepper Bill" (S. 1318) in the Federal Congress, to provide permanently for the health and welfare of mothers, children, and for services to crippled children, would remove the administration of these *curative medical procedures* from established relief agencies and place them under the direction of state health departments which are experienced only in the field of *preventive medicine*. It would throw into the discard the fine record of service to the people built up over the years by such agencies as the probate courts, the Michigan Crippled Children Commission, and local county social welfare boards and boards of supervisors. It would supersede state laws by rules and regulations from a Washington, D. C., bureau which would control and direct the program despite the fact that the state would pay one-half the costs thereof. It would limit a patient's choice of physician to those doctors willing to co-operate with this piecemeal sample of socialized medicine.

That's our problem, gentlemen. How are we going to meet it? It must be met by offensive as well as defensive measures. To be always on the defensive is not enough. To illustrate what we mean by offensive action, may I quote from a talk given before the Presidents of the Medical Societies of seventeen Eastern and Midwestern states in April, and repeated before the Presidents of the Medical Societies of 10 Western states in June? "We in Michigan believe that some changes in methods of medical practice and distribution of medical care are inevitable. We believe that these changes should be evolutionary and guided by the medical profession. We believe that this ideal of controlled evolution is not one to be accomplished easily. We believe that powerful forces are at work bent on revolutionary changes that may completely alter or replace the practice of medicine as a private enterprise. We believe that it's time for medicine to stop playing a defensive game and start carrying the ball.

If we are to preserve our traditional methods of practice and obviate compulsory health insurance with its governmental control and political implications, it seems to us three things are necessary:

1. We must offer voluntary plans that will give to the nation better physical and economic health than is to be expected from any compulsory plan government may offer.

2. We must sell these voluntary plans to the public.

3. We must sponsor and effectuate the passage of legislation that will put these plans into operation."

In other words, and to implement these objectives, we should boost Michigan Medical Service wherever we can; we should continue and improve our radio program and other public relations; and we should support to the fullest extent Dr. Brunk and his committee of Presidents of twenty-five State Medical Societies in their work of drafting and sponsoring proper Health Bills.

On the defensive side in our immediate program, we should give careful consideration to two resolutions that will be brought before the House of Delegates. The first seeks to limit the activities of the Federal Children's Bureau to child welfare, education and research. They should keep out of the practice of medicine. The second expresses our opposition to the Pepper Bill in its present form for reasons that are amply set forth in the resolutions.

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THE VICE SPEAKER: The Speaker's Address will be referred to the Committee on Officers' Reports.

I will turn the meeting back to the Speaker.

(The Speaker resumed the chair.)

THE SPEAKER: The next order of business is the President's Address, Dr. Andrew S. Brunk.

III. President's Address

Gentlemen, in addressing you one year ago, I stated: "Principles worth while must be fought for, to be preserved. Today we are fighting a world war to uphold and maintain a great principle: *freedom under democracy*. It is a costly fight, bringing sorrow and misery, but it is a worthy one. When the battle ends and victory is ours, a great principle shall have been preserved to us but especially to our posterity."

I said that one year ago. Then we were at war. Now we are at peace. But this nation and the world is far from peaceful. Our common outside enemies are gone, but the fight for survival continues.

Let us look at one recent event—*Churchill defeated!*

The turn of events in the politics of England, in recent months, will, I fear, have their immediate reaction in the policies of that war-shattered and destitute country; and it grieves me further to express my sincere thought that the policies of our own beloved country may be tinged, eventually, by the leftist pattern of the British Isles. We would be insulate in our thinking if we dreamed that medicine would remain untouched in a world of social revolution. This is no time for wishful thinking—it is a time for kinetic action. None of us is willing to surrender here—to allow collectivists to take over our profession and the country. *Now* is the hour for *doing*, and the plan of attack is not a new one. It is merely placing into being, on an individual basis, the program of D-Day, *medically* speaking. The public must be aroused to the imminence of the danger of a loss of personal medical treatment. The public must be told of the value of the present-day type of medical practice. The public must be warned that government distribution of medical care may be as inadequate and spotty as government distribution of butter, sugar and other necessities. The public must be more completely embraced in voluntary types of medical care and hospital service. The public must be taken into the confidence of the medical profession. And *you*, Doctor, are the only one who can take the public into your confidence. It will not be done by any others than members of the medical profession. No miracle from on High, or from your disinterested friends outside the profession, can spread the gospel of good medical service to all by *voluntary* means. Only the individual doctor of medicine, his county medical society, and his state medical society will do this vital job. A fight for your very existence as a private practitioner faces you—today. The fight is yours, individually. And you, as a leader in the community, must be proud of this opportunity to save a noble profession from ruin—not alone for today, but for the more important tomorrows. The work is yours, and it is not only a responsibility and a labor, but it is an honor to protect and fight for something which is good and in the interest of the people you serve.

Other state medical societies are doing yeoman's service in this big task of medical public relations. We in Michigan pride ourselves on our pioneering projects. But the field of public relations has merely been topped—it needs deep plowing, and much cultivation. Medical public relations begins at home—with the practitioner of medicine. In his own daily contacts, and through his contribution to his medical organization, the doctor of medicine can win this battle (and battle it is!). I recommend an all-out educational campaign by the medical profession, through the utilization of all ethical means. One hundred dollars spent now on education will accomplish as much as \$500 or \$1,000 spent next year on politics. We need a "war chest" *TODAY*, to inform the people that any necessary *evolutionary* changes in medical practice and its distribution shall come from the medical profession itself, if the interests of the people are to be served. We can't have *revolution* in medicine without the ruination of medicine.

If I may again speak of the past, I would remind you that one year ago I pledged to support enthusiastically

the acceleration of a program of greater information to the people. I urged that our citizens be impressed that only a free science, unchained and untrammelled, can soar to greater heights.

During the past year, the Michigan State Medical Society has done some pioneering activity in this regard. To mention a few projects, the Society has developed an outstanding commercial radio program; it has urged its component county societies to sponsor paid advertising in local newspapers; it has created the "Michigan Foundation for Medical and Health Education" through the earnest, time-consuming efforts of the Society's Postgraduate Foundation Committee (and may I state that we all owe a special debt of gratitude to Dr. Earl I. Carr of this Committee whose research and constant labors over the past many months have made this Foundation into a great reality. Dr. Carr's plans for future expansion of our Foundation will prove, I am sure, the wisdom of his altruistic vision); the Society has stimulated some 25 other states to thought and action along the lines of program development and public information; it has brought the message of medical accomplishments to many hundreds of outstanding national leaders, bankers, industrialists; it has stimulated the Michigan Health Council in its public relations work; and it has urged the creation of a National Health Congress, to integrate similar activity in all the 48 states of the nation.

These labors, and many more of a scientific and socioeconomic nature, have been accomplished by The Council of the Michigan State Medical Society, its officers, its committeemen. Any progress during my tenure of office is due entirely to them. Tonight, at almost the conclusion of 18 years of service as an officer in organized medicine in Michigan, I want to thank them and you all for unfaltering loyalty to your President and to your State Society. May the Michigan State Medical Society continue to hold the respect of the people of this State by continuing to administer the best type of medical care, on a voluntary basis that has made American Medicine the best in the world. That is the greatest principle of our profession—our very life. We must remain alert and become militant so that our great principle, freedom under democracy, may continue to be ours. Thank you, gentlemen, and good luck to you and to the Michigan State Medical Society.

* * *

THE VICE SPEAKER: The President's Address will be referred to the Reference Committee on Officers' Reports.
THE SPEAKER: The next item of business is the Report of the Council, Dr. E. F. Sladek.

IV. Annual Report of the Council

E. F. SLADEK, M.D.: Mr. Speaker, the Annual Report for the Council for the year 1944-45 appears in the Delegates' Handbook, on page 31. I hope you all have read this report.

As this report was written on July 10, in order that it might appear in print, the Council wishes to submit an additional report on matters which it has been considering during the past two months.

SUPPLEMENTAL REPORT OF THE COUNCIL, MICHIGAN STATE MEDICAL SOCIETY SEPTEMBER 17, 1945

1. *Membership.* The membership of the Michigan State Medical Society as of September 15, 1945, totaled 4,609, including 1,201 military members who are granted a remission of dues.

2. *Michigan Rheumatic Fever Control Conference.* "Another First for Michigan" will be chalked up on Wednesday-Thursday, September 19-20 when the Rheumatic Fever Control Conference is held. The excellence of this extraordinary program is best evidence of the pioneering work of the MSMS Committee on Rheumatic Fever Control which is to be congratulated on its first Conference and encouraged in a continuation of its pro-

gressive activities. The Committee's organization of Consultation and Diagnostic Centers throughout the State, in co-operation with the local medical societies, will help the medical profession's efforts to stamp out the most insidious and greatest killer of little children.

3. *MSMS Medical Veterans' Readjustment Program.* This subject is covered in detail in the Annual Report of The Council, under "Matters Referred to The Council by 1944 House of Delegates." Since this report was written early in July, much has happened to change the picture. V-J Day has arrived, and fortunately some of our medical officers in military service soon will be re-deployed back home to take their places in our civilian ranks. It is anticipated that most of our medical veterans who will be separated from military service will return between now and April, 1946. Their postgraduate needs in the immediate future will be great but will be met, thanks to the definite programs developed by the MSMS Committee on Postgraduate Medical Education with the splendid co-operation of the University of Michigan Medical School, Wayne University College of Medicine, and Wm. J. Seymour Hospital at Eloise. The medical veteran who returns to Michigan will find what he wants in postgraduate work waiting for him.

Within the past week, President Brunk has sent a second letter to every MSMS member in military service outlining the definite postgraduate programs of the Michigan State Medical Society and the co-operating agencies indicated above.

Funds arising from the special \$5.00 assessment for the Medical Veterans' Readjustment Program total \$16,723.75 (to September 15, 1945). These monies have been kept in trust for the express purposes of the Program, no part having been spent to date.

4. *Plan of utilizing local practitioners for home and office treatment of veterans,* through Michigan Medical Service. Several meetings have been held with representatives of the Veterans' Administration with a view to negotiating this plan, in order to provide the best type of medical and surgical care to the veteran in his home community by his own family physician—the doctor of his choice. This project is still in the negotiation stage.

The Council recommends to the House of Delegates that it approve such an arrangement with the Veterans' Administration, provided the final plan is satisfactory to all concerned.

5. *Uniform Fee Schedule for Governmental Agencies.* The Special Committee appointed to develop this proposed fee schedule met on September 9 and reviewed 25,000 items in 121 individual fee schedules submitted by county medical societies, hospital staffs, and specialty societies of the State. The Special Committee arrived at a Uniform Fee Schedule for Governmental Agencies which it feels is fair to all parties concerned: first, the patient, second, the doctor of medicine who renders the service or commodity, and, third, the officials responsible for providing medical care to wards of government and to indigents.

The Council recommends that the House of Delegates adopt the Uniform Fee Schedule for Governmental Agencies, subject to its final approval by the Special Committee which shall review and adjust any controversial items within the next thirty days; and that the House of Delegates authorize The Council to declare the Uniform Fee Schedule for Governmental Agencies in effect and operative upon receipt and approval by The Council of the final report of the Special Committee.

6. *Problem of Ethics*—A petition relative to the long-standing problem at the Soo will be presented by The Council to the House of Delegates at this session.

7. *The 1944 Michigan Survey of Public Opinion.* This survey, sponsored by the Michigan Health Council, was presented to the MSMS House of Delegates in September, 1944—just one year ago. One important conclusion reached by this Survey was as follows:

Despite the fact that 91.6% of the people of Michigan feel that doctors of medicine as a group are doing a

good job for the public, the people have complaints. Their "pet peeves" regarding the medical profession are summed up in four classifications: of the small percentage with complaints, 6.5% felt that doctors overcharge; 4.4% complain that physicians keep patients waiting; 1.7% are of the opinion that doctors lack interest in their patients; and 5.6% felt that some doctors are dishonest. *The elimination of these complaints is the first responsibility of the medical profession.* As leaders in thought and action in their counties, the individual Delegates of the Michigan State Medical Society and the officers of the county medical society have the major responsibility of reminding their constituents of the public's "pet peeves," and taking means to eliminate them. After that has been accomplished, the profession's voluntary program plus the public relations work of the Michigan State Medical Society, will be so effective that no individual or group—no matter how powerful they may be—can force the people to accept a compulsory system of government-controlled and operated medicine.

8. *Voluntary Interim Commission of MSMS.* A proposal for a semi-official study of the availability and distribution of privately and publicly financed, medical service in Michigan was made by the General Counsel to the Executive Committee of The Council last April. The purposes of this proposal were, first, to demonstrate that the medical profession recognizes its responsibility for constructive action on this subject; second, to obtain facts in order to evaluate demands for state medicine.

The survey should demonstrate clearly the extent of health services afforded by various governmental units; by semi-public organizations such as the various foundations in Michigan; by other non-profit organizations (such as Michigan Medical Service); by insurance programs and industrial plans. It should also afford the MSMS a reliable guide for the broadening of its program of prepaid medical services and for the distribution of health facilities and physicians. These data, properly compiled, should result in an attractive, understandable, and forceful document.

The plan has been presented to state officials whose co-operation is necessary to obtain the type of information needed, and their reaction has been most favorable.

The Council is now exploring the avenues of the proposed study, its probable scope and cost and methods to obtain proper financing thereof.

9. *National Health Congress.* In the printed Annual Report of The Council under "Miscellaneous," a report is presented on the letter President Brunk sent to 1,400 leading industrialists, bankers and civic leaders of the nation outlining the threat to free enterprise by governmental control of medicine, and seeking the thinking support of these national leaders; in addition, Dr. Brunk enclosed a reprint suggesting that a "National Health Congress" be incorporated to band together doctors of medicine, hospital executives, dentists, pharmacists, etc., in a joint effort to expend health service to all the people.

The Council endorses the proposed creation of a "National Health Congress" as a strong vehicle to bring about the greatest distribution of health protection to all the people of this nation and to preserve and extend the high standards of health now prevailing in this country.

The Council recommends that the House of Delegates approve the creation of such a legislative body.

10. *Public Education Account of 1944-45.* This fund, accumulated from the special \$10 assessment levied by the 1944 House of Delegates, had been kept separate from the other funds and accounts of the Michigan State Medical Society and has been used exclusively for public educational purposes, as indicated by the following accounting of disbursements (up to September 15, 1945):

PUBLIC EDUCATIONAL ACCOUNT FINANCIAL
REPORT—TO SEPTEMBER 15, 1945

School of Information (1/28/45).....	\$ 2,515.93
Purchase of Pamphlets.....	368.24
Michigan Health Council.....	5,000.00
Radio Program.....	17,338.14
Publicizing Radio Program.....	1,168.00
Miscellaneous	44.06
	<hr/>
	\$26,434.37

The unspent balance is already allocated for the same and similar public education activity.

11. *Information to the Public.* Today critical problems face medicine: the Wagner-Murray-Dingell Bill, Senator Pepper's \$100,000,000 super-EMIC measure, the hard-boiled demands of labor groups for reforms including broader social security benefits and *health insurance*. Undoubtedly another socialized medicine bill will be introduced into the Michigan Legislature of 1947 and will be pressed vigorously. All this means that organized medicine is forced to carry a greater load during 1946 in order to foster voluntary medical service as opposed to compulsory political programs.

Other progressive state medical associations realize the threat and have developed counter-offensives. One State Society which has already evolved a splendid program of health care, including a successful pre-pay medical service plan, is going into a strong public relations activity which will include the use of newspaper advertising, radio time, lay and professional public speakers, editorial and publicity service, printed material, and all other public relations media; this society is organizing its Woman's Auxiliary to take an active part, and is arranging meetings with business and insurance leaders; its program, which will run to six figures in cost, is being developed on the *principle of state rights* and on the solid foundation of the private practice of medicine aided by the framework of voluntary group medical care plans. That State has increased its 1946 dues from \$20 to \$100 to develop a fund for vital public relations activity.

The answer is obvious. If the attack is made on the state level (which appears likely), we have only fifteen months to perfect our program for the people and do a mammoth and costly job of public relations. The work of organized medicine during the next fifteen months will tell the story. After that, it may be altogether too late.

A continuation and expansion of our program of information, first to the profession, and, secondly, to the people, is absolutely necessary. Every member of the profession must know what social, economic, and political issues are facing him. *Every person in the State of Michigan must be told the facts about medical service, distribution and costs.* The medical profession must fight to preserve the private practice of medicine as we know it, in the interests of the people we serve. That fight must be well financed, or it will be lost.

The Council recommends that the House of Delegates give serious consideration to the vital need for an increased public educational campaign aimed to prove that the best medical care for all the people is available only through voluntary methods, and it also recommends that the House of Delegates consider ways and means of properly financing this important and necessary project of 1946.

Respectfully submitted,

E. F. Sladek, M.D., Chairman
O. O. Beck, M.D., Vice Chairman

R. S. Morrish, M.D.	D. W. Myers, M.D.
O. D. Stryker, M.D.	A. H. Miller, M.D.
C. E. Umphrey, M.D.	W. E. Barstow, M.D.
P. A. Riley, M.D.	E. R. Witwer, M.D.
Wilfrid Haughey, M.D.	W. H. Huron, M.D.
R. J. Hubbell, M.D.	P. L. Ledwidge, M.D., Speaker
T. E. DeGurse, M.D.	A. S. Brunk, M.D., President
F. H. Drummond, M.D.	L. F. Foster, M.D., Secretary
A. B. Smith, M.D.	Wm. A. Hyland, M.D., Treasurer

PROCEEDINGS OF HOUSE OF DELEGATES

THE SPEAKER: The report will be referred to the Reference Committee on Reports of the Council.

The next order of business will be the Report of Delegates to the American Medical Association, Henry A. Luce, M.D., Chairman.

V. Report of Delegates to AMA

HENRY A. LUCE, M.D.: Mr. Speaker and Members of the House of Delegates: You are all aware of the federal restrictions on assembly and transportation. There has been no meeting of the American Medical Association House of Delegates this year so far. Today the delegates received notice, through the State Society, from the American Medical Association, that there would be a meeting of the House of Delegates of the American Medical Association, December 3 to 6 of this year. If there are any directives arising from this meeting, your representatives will be glad to convey them to the national body.

In addition, your representatives will report to the Midwinter meeting of the Council officially regarding the actions of the House of Delegates of the American Medical Association in December.

Thank you, Mr. Speaker.

THE SPEAKER: Thank you, Dr. Luce. This report will be referred to the Reference Committee on Officers' Reports.

The next order of business is resolutions. Resolutions are now in order.

VI. Resolutions

VI-1. RESOLUTION RE U. S. CHILDREN'S BUREAU

R. A. JOHNSON, M.D. (Wayne):

WHEREAS, The recommendations concerning Maternal and Infant Care adopted by the Steering Committee on Health Services, advisory to the United States Children's Bureau, United States Department of Labor, adopted January 28, 1945, would give the Children's Bureau almost unlimited powers, and

WHEREAS, The recommendations would place the Bureau in the field of public health where it does not belong, and would place a large section of the practice of medicine under the domination of a lay-controlled bureau, and

WHEREAS, The Children's Bureau has used World War II as an excuse to enlarge its powers on the basis of patriotism, and

WHEREAS, The past practice of this body has been to issue directives affecting medical practice without consideration of the opinions of, or consultation with practicing physicians, and

WHEREAS, The Children's Bureau appears to be the experimental station for the piecemeal socialism of medical practice, leading eventually to socialization of the whole, therefore, be it

RESOLVED, That the activities of the United States Children's Bureau be limited to education and research, and its powers be not increased to include control of the practice of medicine, in part or in whole; and be it further

RESOLVED, That copies of this resolution be forwarded to the Secretary of Labor, the Chief of the Children's Bureau, to the Michigan members of Congress, to the members of the Congressional Committees which normally consider Maternal and Infant Care proposals, to the American Medical Association, and to the Secretary of every State Medical Society.

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

VI-2. SPECIAL MEMBERSHIPS

A. E. CATHERWOOD, M.D. (Wayne):

WHEREAS, Thomas B. Cooley, M.D., is an honor member of the Wayne County Medical Society and has engaged in the active practice of medicine for fifty years, and

WHEREAS, Dr. Cooley has been a member of the Michigan State Medical Society in good standing for well over the twenty-five years as prescribed in the By-laws, and

WHEREAS, Dr. Cooley has maintained an ethical practice and contributed greatly to the welfare of the public and the advancement of the profession, particularly as a distinguished pediatrician and as a contributor to medical literature, and

WHEREAS, The Council of the Wayne County Medical Society recommends that he be favorably considered for Emeritus Membership in the Michigan State Medical Society, therefore, be it

RESOLVED, That Thomas B. Cooley, M.D., of Detroit, Michigan, be elected by this House of Delegates to Emeritus Membership in the Michigan State Medical Society.

Another resolution—

WHEREAS, J. Whitlock Gordon, M.D., of Detroit, Michigan, has retired from the active practice of medicine, and

WHEREAS, Dr. Gordon was born in 1892, was graduated from the University of Cincinnati Medical College in 1917, and has long served the community and his medical societies with skill and dignity, and

WHEREAS, The Council of the Wayne County Medical Society has accredited Dr. Gordon with special membership recognition; therefore be it

RESOLVED, That the name of J. Whitlock Gordon, M.D., of Detroit, Michigan, be placed on the list of retired members of the Michigan State Medical Society.

THE SPEAKER: These resolutions will be referred to the Reference Committee on Officers' Reports. That sounds a little bit peculiar, but it is to take some of the work off the Resolutions Committee.

GEORGE WATERS, M.D. (St. Clair): Mr. Speaker and Members of the House of Delegates: At a meeting of St. Clair County Medical Society held June 19, 1945, the following resolution was adopted:

WHEREAS, Duncan J. McColl, M.D., of Port Huron, a member of St. Clair County Medical Society, has been in practice for over fifty years and has maintained a membership in good standing in the State Society for over twenty-five years, therefore, be it

RESOLVED, That he be recommended for Member Emeritus.

At a meeting of St. Clair County Medical Society held June 19, 1945, the following resolution was adopted:

WHEREAS, William P. Derck, M.D., of Port Huron, a member of St. Clair County Medical Society, has been in practice for over fifty years and has maintained a membership in good standing in the State Society for over twenty-five years, therefore, be it

RESOLVED, That he be recommended for Member Emeritus.

At a meeting of St. Clair County Medical Society held June 19, 1945, the following resolution was adopted.

WHEREAS, James A. Attridge, M.D., of Port Huron, a member of St. Clair County Medical Society, has passed the age of seventy, and has been an active member in the State Society for more than ten years, therefore, be it

RESOLVED, That we recommend that he be transferred to the Life Membership Roster by election of the House of Delegates.

At a meeting of St. Clair County Medical Society held June 19, 1945, the following resolution was adopted.

WHEREAS, Albert L. Callery, M.D., of Port Huron, a member of St. Clair County Medical Society, has passed the age of seventy, and has been an active member in the State Society for more than ten years, therefore, be it

RESOLVED, That we recommend that he be transferred to the Life Membership Roster by election of the House of Delegates.

THE SPEAKER: These resolutions will be referred to the Reference Committee on Officers' Reports. Are there other resolutions?

VI-3. PUBLIC RELATIONS

C. L. CANDLER, M.D. (Wayne):

Whereas, The economic trends of medicine point to an increasing effort on the part of organized minorities to regiment medicine, and

Whereas, it behooves the medical profession to take the public into its confidence and tell the people what organized medicine is doing for the public good,

Whereas, The Michigan State Medical Society has had an urgent need for a full-time public relations counsellor to properly inform the public on its ideals and programs, and

Whereas, The officers of the Michigan State Medical Society have long been cognizant of this need, and

Whereas, Such personnel is now available, therefore, be it

Resolved, That the House of Delegates recommend to the Council of the Michigan State Medical Society that a public relations man with good newspaper connections be hired immediately.

THE SPEAKER: This resolution will go to the Reference Committee on Reports of the Council.

VI-4. UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES

C. F. BRUNK, M.D. (Wayne):

Whereas, The physical restoration program and other medical services necessarily financed by government portend to be of vast proportions and great consequence, particularly during the next few years, and

Whereas, In the light of modern conditions, changes and trends, and the creation of vast new groups and categories, the medical profession can hardly be expected to continue delivering its commodity of service to governmental agencies at less than cost, therefore, be it

Resolved, That hereafter the minimal fee for medical care of wards of government and indigents shall be commensurate with the work done, and be it further

Resolved, That the fees in the Uniform Fee Schedule for Governmental Agencies, as developed by the

Michigan State Medical Society, be considered the minimal fees for the service named, subject to revision in unusual cases—such unusual cases to be reviewed by a special board of doctors of medicine appointed by the Michigan State Medical Society and be it further

Resolved, That the Uniform Fee Schedule for Governmental Agencies of the Michigan State Medical Society be herewith adopted, subject to final approval by the Committee appointed by the Council which shall review and adjust any controversial items within the next thirty days; and be it further

Resolved, That the Council of the Michigan State Medical Society is hereby authorized to declare the Uniform Fee Schedule for Governmental Agencies in effect and operative upon receipt and approval of the final report of the Committee appointed by the Council; and be it further

Resolved, That the members of the Michigan medical profession stand united behind the Uniform Fee Schedule for Governmental Agencies, as developed and adopted by the Michigan State Medical Society, and be it finally

RESOLVED, That the county and district medical societies of the Michigan State Medical Society make special efforts, immediately, to negotiate necessary revisions in schedules of benefits governing governmental wards and indigents so that the medical profession is not penalized by being forced to perform services at a financial loss and below the fees indicated in the Uniform Fee Schedule for Governmental Agencies.

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

VI—5. MEDICAL VETERANS READJUSTMENT PROGRAM

W. W. BABCOCK, M.D. (Wayne):

WHEREAS, There is now approximately \$16,723.75 in the State Treasury for postwar planning, and

WHEREAS, There has not been the need for a paid counsellor on postwar adjustments, and

WHEREAS, It now appears that there is a scarcity of physicians, and that this scarcity will continue for several years because of the increased ratio of physician deaths as compared to physicians graduating, and

WHEREAS, It now appears that the releases from the armed forces will be gradual with many electing to stay in our greatly enlarged Navy and Army, as well as entering the Public Health and Veterans' Service, be it

RESOLVED, That each component county society set up its own county society information bureau to the extent needed by the Society in caring for its returned medical veterans, and also be it further

RESOLVED, That the money now in the State Treasury be used in the formation of a State Information Bureau on Postwar Planning. That pertinent information be published from time to time in the State Journal and that all information be readily accessible to the various component County Societies and to all discharged Medical Veterans. And that the Postwar Planning Committees of the various County Societies co-operate with the State Society in assembling data for use by the State Society and themselves. That it shall be the duty of the State Information Bureau on Postwar Planning to collect data on residencies, refresher courses, locations to practice, methods of securing loans to establish practice or for educational purposes and all other matters pertinent to the problems of the returned medical veteran.

VI—6. VETERANS ADMINISTRATION HOME OFFICE CARE

WHEREAS, The Veterans Administration is having difficulty in handling the many medical problems of the returned veterans, and

WHEREAS, The present difficulties will be greatly increased now that the war is concluded so that the present overtaxed facilities will be completely overwhelmed, and

WHEREAS, The location of the various veterans' hospitals often presents extreme difficulty to veterans in obtaining treatment, and

WHEREAS, The cost of transportation to the Government for transportation of the veteran to and from the various veterans' facilities would be eliminated, and

WHEREAS, The time lost to the veteran in transportation to available veterans' facilities would be largely eliminated, and

WHEREAS, The cost to the Government to build additional necessary veterans facilities would be very large and consist of unnecessary duplication if existing local civilian facilities are not used, and

WHEREAS, The proper professional personnel to staff and maintain additional facilities would be difficult to secure, and

WHEREAS, The veterans facilities for the care of the ambulatory veteran are inadequate and poorly located, and

WHEREAS, At present ambulatory patients are now unnecessarily hospitalized to the distaste of the veteran plus additional expense to the public, and

WHEREAS, Such a policy necessarily reduces an already limited bed capacity, thus often depriving the acutely ill veteran of bed space, and

WHEREAS, We, the physicians of the State of Michigan firmly believe that a policy of forcing a patient into the care of one not of his own choice is against the Democratic principles upon which this country is founded, and

WHEREAS, The veteran could be well cared for by his family physician with a saving of time, convenience and expense, and

WHEREAS, We, the physicians of the State of Michigan heartily endorse the maintenance of the family physician-patient relationship, and

WHEREAS, There is a medical organization in the State of Michigan known as Michigan Medical Service, that maintains aforesaid relationships, and

WHEREAS, The Medical Society of the State of Michigan has been approached by various veterans' organizations requesting it to obtain the co-operation of the doctors of Michigan, be it therefore

RESOLVED, That the doctors of the State of Michigan urge that the Veterans' Administration avail itself of the medical services of all the doctors of medicine of the State of Michigan through the Michigan Medical Service, furthermore, and

WHEREAS, There is an urgent immediate need for this action, be it therefore,

RESOLVED, That the House of Delegates of the Michigan State Medical Society hereby empower the Council of the Michigan State Medical Society and Michigan Medical Service, in co-operation with various veterans' organizations and with the Veterans' Administration, to formulate a just and equitable fee schedule and procedure. This schedule to be subject to revision by the House of Delegates annually or in special meeting called for that purpose.

VI—7. MEDICAL VETERANS' BENEFITS

AMENDMENT TO TITLE II, Public 346, 78th Congress.

WHEREAS, The Veterans' Administration has interpreted Paragraph 5 of Part VIII, Title II, Public 346, 78th Congress to mean that for a course of education or training which is set up for a period of time less than thirty weeks, they may pay only that amount which bears the same relation to the maximum amount allowed by the law (\$500) as the length of the course bears to an ordinary school year of thirty weeks, and

WHEREAS, The House of Representatives did, on July 18, 1945, pass HR 3749 to amend the Servicemen's Readjustment Act of 1944 and failed to correct paragraph 5 of Part VIII, Title II, Public 346, 78th Congress so that the Veterans' Administration will not deny to medical veterans full payment of tuition for refresher courses of less than thirty weeks duration, and

WHEREAS, Most medical refresher courses are organized for much shorter periods than thirty weeks, and

WHEREAS, Surveys conducted by the American Medical Association indicate that a substantial number of medical veterans will desire short term refresher training, and

WHEREAS, The present law, the so-called GI Bill of Rights, as interpreted by the Veterans' Administration, will deny to such medical veterans the refresher training they desire and which they have been led to believe they could get at Government expense, therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society, in convention assembled, do unanimously protest this discrimination against medical veterans as being contrary to the intent of the Congress and the spirit of fairness of the American people, and be it further

RESOLVED, That the House of Delegates requests the members of Congress from the State of Michigan to work for amendment of this law to the end that the full tuition for all courses of education of less than thirty weeks be paid for by the Government for veterans, provided that in no event shall such payments with respect to any person exceed \$500 within any single year, and be it further

RESOLVED, That a copy of this resolution be furnished each Senator and Representative from the State of Michigan, and be it further

RESOLVED, That a copy of this resolution be furnished to the Committee on Pastwar Medical Service of the American Medical Association with a request that they use their good offices to further this resolution.

VI—8. MEDICAL VETERANS' LOANS

AMENDMENT TO TITLE III, Public Act 346, 78th Congress

WHEREAS, The House of Representatives, taking cognizance of the complicated process of obtaining business loans under Title III of Public 346, 78th Congress, did on July 18, 1945, pass HR 3749 to amend this act, and

WHEREAS, The amendment removes most of the faults of the present Servicemen's Readjustment Act of 1944 except that under Sec. 500 (a), Chapter V, Title III of HR 3749, the new act provides that no loan shall be negotiated until thirty days after the date of the veteran's discharge, and

WHEREAS, Many medical veterans cannot wait thirty or more days after discharge to establish themselves in private practice without undue hardship upon themselves, their families and the community, therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society, in convention assembled, recommend to the Senate of the United States the adoption of the amendment of Title III of Public 346 as proposed in HR 3749 provided that the thirty days waiting period under Sec. 500 (a), Chapter V, Title III of HR 3749 is modified, and be it further

RESOLVED, That a copy of this resolution be furnished to each of the Senators from the State of Michigan.

VI-9. MEDICAL VETERANS' RELEASE FROM SERVICE

WHEREAS, With the cessation of hostilities the need for medical officers in the armed forces is greatly reduced, and

WHEREAS, The President of the United States has announced that the armed forces will be reduced in size by from five to seven million men during the next year, and

WHEREAS, During the period of the war the civilian supply of physicians has been reduced by some 60,000 who volunteered for military service and was further reduced by more than 20,000 by deaths among civilian physicians, and

WHEREAS, During the period of the war, replacement of physicians in civilian practice has been practically nil, and

WHEREAS, There is an urgent need for the return to civilian practice of many thousands of physicians now in the armed forces, therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society strongly urge that every physician in the armed forces who can possibly be spared and whose duties are not essential to the health and care of our own military personnel be released from service with least practicable delay, and be it further

RESOLVED, That a copy of this resolution be furnished to each Senator and Congressman from the State of Michigan to the Secretary of War, the Secretary of Navy, and to the Surgeon General of the Army, Navy and Public Health Service, and to the American Medical Association.

VI-10. UNIFORM FEE SCHEDULE—VETERANS

WHEREAS, Various Government Agencies are now predicting an unemployment total of 8,000,000 workers, and

WHEREAS, The medical facilities of municipal, county, state and Governmental Agencies will be sorely taxed during such a period of unemployment, and

WHEREAS, The returned medical veteran will be anxious to re-establish his old practice or build up a new one, be it therefore

RESOLVED, That the House of Delegates of the Michigan State Medical Society hereby empower the Council of the Michigan State Medical Society and Michigan Medical Service in co-operation with the various municipal, county, state and governmental agencies interested, to formulate just and equitable fee schedules and procedures, such schedules to be subject to revision by the House of Delegates annually.

VI-11. MEDICAL VETERANS' RELEASE BY RATIO

WHEREAS, The Senate of the United States has seen fit, by Senate Resolution No. 134, to cause a subcommittee of the Senate Military Affairs Committee to investigate the disparity between the ratio of civilian doctors to the population as compared with ratio of medical officers to soldiers, and

WHEREAS, In 1942 the War Manpower Commission set up the ratio of one doctor to each 1500 of the civilian population as a safe ratio for adequate medical care in this emergency, and

WHEREAS, It is reliably reported that the civilian ratio is now one to 1800 while the military ratio is one to 180, and

WHEREAS, Since 1942 there have been practically no replacements in the field of civilian medicine despite an annual death rate among civilian physicians of more than 7000 and an appreciable increase in the total civilian population, and

WHEREAS, The Army is in the process of discharging several million men, thus reducing the overall need for medical officers, and

WHEREAS, Rather than reducing the number of medical officers there has been a net gain of approximately 600 since January 1, 1945, therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society, in convention assembled, commend this action on the part of the Senate of the United States and urge that every effort be made to expedite the return to civilian practice of every medical officer who it is found can be spared from military service without endangering the lives or health of our armed forces, and be it further

RESOLVED, That a copy of this resolution be furnished to the Senators from Michigan; to Senator Thomas of Utah, Chairman of the Senate Military Affairs Committee; to Senator Downing of California, Chairman of the subcommittee appointed to carry out the provisions of S.R. 134 and to the Secretary of War.

SPEAKER: All Resolutions presented by Dr. Babcock will be referred to the Reference Committee on Resolutions.

VI-12. PEPPER BILL

R. V. WALKER, M.D. (Wayne): This is a resolution relative to the Pepper Bill in the United States Congress, Senate Bill 1318.

WHEREAS, The Pepper Bill in the 1945 Congress (S. 1318), to provide permanently for the health and welfare of mothers and

of children from birth to 21 years of age, and for services to crippled children and for other purposes, would remove the administration of these curative medical procedures from established relief agencies and place them under the direction of State Health Departments; and

WHEREAS, State Health Departments have specialized in the field of preventive medicine and have little knowledge, training or aptitude for curative medicine which is a wholly different field; and

WHEREAS, Existing agencies, such as the Michigan Crippled Children Commission, probate courts and local county social welfare departments, have built up a fine record of service in behalf of the people whom they serve, by state law, and deserve to be continued in the administration of this work; and

WHEREAS, States which accept this program must provide matching funds which will of necessity be controlled and expended by a federal bureau, with little or no voice left to the state; and

WHEREAS, State laws will undoubtedly be superseded by rules and regulations dictated by a federal bureau; and

WHEREAS, Under the Pepper Bill (S. 1318), only those physicians who choose to participate in the program will be available for this socialized medical service—which means that patients desiring their own physicians who are not co-operating will not be permitted a free choice unless they pay the service again (double taxation); and

WHEREAS, A minimal ward-type service—which pauperizes all who accept it—is provided under the present Emergency Maternal and Infant Care Program of the United States Children's Bureau, which the Pepper Bill appears to expand and perpetuate in S. 1318; therefore be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society disapproves the Pepper Bill (S. 1318 of 1945) as drafted because it will fail to provide competent and adequate medical care for mothers, children, crippled children and others, and because the passage of this proposal in its present form would tend to pauperize patients who are financially independent and to limit free choice of physician.

THE VICE SPEAKER: This will be referred to the Committee on Resolutions.

VI-13. RESOLUTION ENDORSING MICHIGAN MEDICAL SERVICE

W. B. HARM, M.D. (Wayne):

Whereas, Michigan Medical Service has provided the means whereby almost one million people in this State have been able to secure good medical care on a voluntary budgeted basis; and

Whereas, This medical care has been rendered in a manner which has been generally highly satisfactory to both physician and patient; and

Whereas, This has resulted in better feeling and understanding between the public and the medical profession; and

Whereas, The voluntary type of group medical service, as exemplified by Michigan Medical Service, is to be preferred—in the interest of the people's health—to compulsory schemes and political control; therefore be it

Resolved, That the House of Delegates of the Michigan State Medical Society urgently request every doctor of medicine in this state to recognize the values to his patients and to himself of Michigan Medical Service, that every physician endorse the service and become a subscriber (policy owner) thereof, and further, that every practitioner of medicine constantly spread the word concerning the advantages of the voluntary, medical-society-sponsored program of group medical care to all his patients, friends and acquaintances, to the end that the protection of Michigan Medical Service is available to all persons in this State, thus obviating any desire or need for bureaucratic medicine.

VI-14. CHANGE IN THE SYSTEM OF MEDICAL CARE

WHEREAS, Sixty thousand or practically one-third of all the doctors of medicine of the United States are now in the Armed Services of their country, and

WHEREAS, These physicians have ably proved their loyalty to their country and the American way of life, and

WHEREAS, Their services have been highly lauded both by their superior officers and the men they have served, and

WHEREAS, At the present time there is much agitation for a change in the system of medical care as practiced in this country, and

WHEREAS, These physicians, because of military restrictions at the present time, are forbidden to express their views on this matter and have even been threatened with disciplinary action if they should do so, and

WHEREAS, The 10,000,000 men they have so faithfully served are under the same restrictions and are unable to express their opinion as to whether they prefer to receive medical care under a socialized system or one of individual enterprise, and

WHEREAS, The majority of these physicians and the men served will be released to civilian life with the termination of the war emergency, therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society, hereby assembled, request that any decision on a change of the present system of medical care be delayed until such physicians and the men they served are returned to positions in civilian life so that they may be privileged to vote and express their views on this serious problem and that copies of this resolution be sent to the President of the United States and to the Congressional representatives of the State of Michigan.

THE VICE SPEAKER: That will be referred to the Resolutions Committee.

VI-15. ASSESSMENT (\$25) FOR PUBLIC RELATIONS AND INFORMATION

P. E. SUTTON, M.D. (Oakland): This resolution has to do with the raising of funds for medical public relations.

Whereas, Some changes in the distribution of medical care, for the benefit of the people, have been effected by the Michigan medical profession through evolutionary methods; and

Whereas, Improvement in medical service and in its distribution is the constant aim of the medical profession which will never cease its endeavors to bring good medical care to all the people; and

Whereas, Not all the people of our State have been made aware of the salutary efforts of the Michigan medical profession, despite the work of public information performed by the Michigan State Medical Society, especially during the past two years; and

Whereas, One or more of the most progressive state medical societies have markedly increased their dues or levied special assessments to develop a fund sufficient to carry on an adequate program of medical public relations, therefore, be it

Resolved, That a per capita assessment of twenty-five dollars (\$25.00) be levied for the year 1946 for purposes of public education and public relations.

THE SPEAKER: This will be referred to the Committee on Resolutions.

VI-16. VETERANS' ADMINISTRATION HOSPITAL CONTRACT

M. A. DARLING, M.D. (Wayne):

WHEREAS, The United States Veterans' Administration has been circularizing hospitals with a form of contract entitled "Proposal for the Hospital or Sanatorium Care of Beneficiaries of the Veterans' Administration" which in effect is an offer on the part of a hospital which executes this contract to furnish and sell to the Veterans' Administration not only hospital services but medical and dental care as well, and

WHEREAS, Under this contract, payment is to be made not to the doctor of medicine or to the doctor of dentistry but directly to the contracting hospital, and

WHEREAS, This agreement is one for the practice of medicine by hospital which is clearly objectionable and illegal, therefore, be it

RESOLVED, That firm objections be made to the form of the Veterans' Administration's present contract with hospitals, and that the American Medical Association be respectfully requested to endeavor to have the Veterans' Administration immediately modify the contract to avoid the patently illegal practice of medicine by hospitals, and be it further

RESOLVED, That the Council of the Michigan State Medical Society be instructed to make known to the Michigan Hospital Association the serious objections of the Michigan medical profession to this type of contract which calls for the practice of medicine by a hospital, and that the Michigan Hospital Association be requested to urge its individual member hospitals not to enter into such a contract and to terminate existing agreements of this type as soon as possible, and be it further

RESOLVED, That copies of this resolution be published as a special article in the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, be forwarded to the Editor of the *Journal of the American Medical Association*, and to the Secretaries and Editors of all other State Medical Societies.

VI-17. MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION

Whereas, The purposes of the Michigan Foundation for Medical and Health Education, created by the Michigan State Medical Society, are "To acquire, provide, use, develop, endow, and finance methods, means and facilities for postgraduate education in

medicine, for education in medicine, for lay health education, and for research, fellowships, and scholarships," and

Whereas, Many persons are seeking outlets through the medium of tax-exempt foundations for their surplus funds, and

Whereas, numerous doctors of medicine and laymen would contribute to the Michigan Foundation for Medical and Health Education if they were made aware of its existence and its humanitarian purposes, therefore, be it

Resolved, That the House of Delegates of the Michigan State Medical Society earnestly invite individual members of the State Medical Society to contribute during life and in their last wills to the "Michigan Foundation for Medical and Health Education," and be it further

Resolved, That Michigan doctors of medicine be urged to encourage interested laymen to aid this worthy fund devised to benefit the health of our people through the aegis of a well-informed medical profession.

VI-18. MICHIGAN'S MEDICAL MEN IN MILITARY SERVICE

Be it resolved, That the House of Delegates of the Michigan State Medical Society give recognition to the valiant and super-sacrificing services rendered by the 2287 Michigan Doctors of Medicine who entered the armed forces in defense of our country; many of these medical officers labored in perilous surroundings and under conditions too terrible to imagine; the State Society wishes these courageous medical soldiers and sailors a speedy return to their home state, now that victory has come to the Allies and the conflict is ended; and be it further

Resolved, That the House of Delegates of the Michigan State Medical Society honor those of its members who have made the supreme sacrifice in World War II, by standing for a moment with bowed heads in their memory, and further by requesting the Council to list their names on an appropriate scroll which shall be displayed permanently at the headquarters of the Michigan State Medical Society.

THE SPEAKER: The first of these resolutions will be referred to the Reference Committee on Resolutions, and the last two to the Reference Committee on Officers' Reports.

VI-19. NATIONAL HEALTH CONGRESS

A. V. WENGER, M.D. (Kent):

Whereas, Proposed federal legislation to socialize medical service would regiment doctors of medicine, dentists, hospitals, nurses, pharmacists, and the people whom they serve; and

Whereas, The medical and allied health professions are intensely interested in bringing the greatest amount of health protection to all people in this nation, but solely through those means which will both preserve and extend the high standards of health now prevailing in this country; and

Whereas, While each of the groups in the medical field has its own organization, no over-all body or council exists to integrate the necessary collective thinking and activity of the several units; and

Whereas, In order to preserve quality health care to the people of this nation, each of these groups favors voluntary health plans in contrast to compulsory political control of medical service; and

Whereas, A serious and immediate need exists to develop a working liaison or Congress of all agencies in the medical world which if not united in thought and action may soon face sudden extermination as independent practitioners; therefore, be it

Resolved, That the House of Delegates of the Michigan State Medical Society recognize the need for a National Health Congress representative of

the medical, dental, hospital, nursing and pharmaceutical professions, and that it approve the creation of such a legislative body; and be it further

Resolved, That copies of this resolution be sent to the American Medical Association, its Council on Medical Service and Public Relations, to all state medical societies, and to the National District and State Associations of the Dental, Hospital, Nursing and Pharmaceutical professions.

THE SPEAKER: This resolution will be referred to the Reference Committee on Reports of the Council.

VI-20. DRAFTING COMMITTEE'S OUTLINE

S. W. INSLEY, M.D. (Wayne): This resolutions has to do with the report of the Special Drafting Committee on the Outline of Mental Care Program, a copy of which you all have in your envelopes.

Whereas, The Drafting Committee on Legislation of the Michigan State Medical Society has developed an "Outline" of general principal which the Michigan medical profession favors in any program of proposed legislation affecting medicine; and

Whereas, This Outline is being used as a pattern by other State Medical Societies, particularly those represented at the Detroit and Denver Public Relations Conferences of last spring; and

Whereas, President A. S. Brunk of the Michigan State Medical Society, as Chairman of the Presidents of Twenty-six States, has been requested to integrate Outlines on proposed legislation developed by the various State Societies and to submit the final program to the American Medical Association Council on Medical Service and Public Relations, for action; therefore, be it

Resolved, That the "Outline" developed by the Michigan State Medical Society's Drafting Committee on Legislation be approved; and be it further

Resolved, That the President of the Michigan State Medical Society be authorized to co-operate with all other State Medical Societies in early attempts to correlate a positive program of needed medical legislation which the medical profession of the nation can submit to legislative bodies as its own, through the American Medical Association.

THE SPEAKER: This resolution will be referred to the Reference Committee on Reports of the Council.

VI-21. GENERAL PRACTICE SECTION

ARCH WALLS, M.D. (Wayne): This is a resolution in regard to the formation of a General Practice Section of the American Medical Association.

Whereas, Sixty-six and two-thirds per cent (66 $\frac{2}{3}$ %) of the doctors of medicine of this nation are general practitioners, and these general practitioners constitute the bulk of the membership of the American Medical Association, and

Whereas, General Practice is an entity of and by itself within the profession, just as much as the established specialty fields, and is definite in its comprehension and limitless in its extension, and

Whereas, The organized specialty groups have set up certain restrictive rules and regulations concerning important portions of the field of general practice, which rules and regulations cannot be met and surmounted in the aggregate by the physicians who are making general practice their life's work, and

Whereas, The organized specialty groups have assumed the position generally of directing the affairs of the entire profession, and

Whereas, Forty per cent (40%) of surgery and fifty per cent (50%) of obstetrics are efficiently performed by well-trained General Practitioners, and

Whereas, The public attitude is affected unfavorably by the standing inference that General Practitioners are inferior to and supervised by the organized specialty groups, and

Whereas, Efforts to date looking toward the creation of an official section of General Practitioners in

the AMA have met with disapproval, and no sufficiently good reasons have been advanced for denying the General Practitioners this vital means by which they can help themselves to face and solve their own particular problems, and

Whereas, General Practitioners are constantly engaged in continuation study to increase their proficiency along practical lines and are developing more suitable programs of clinical study, as is evidenced by statistics from one section of the country which shows that sixty per cent (60%) of those in attendance at postgraduate courses (in medicine) are general practitioners, and

Whereas, No place has been provided on hospital staffs through which General Practitioners would be enabled to submit their evidence of special training in certain fields of medicine and surgery which would qualify them before the public as proficient therein, and

Whereas, General practitioners have a special interest in medical legislation, administration and jurisprudence, which justifies their particular voice being officially heard, and

Whereas, It is not the desire of the General Practitioner to disrupt the splendid variety and calibre of scientific programs of the AMA but rather to create a new and proper basis for separate registration, representation and participation in the general activities of the organization, and

Whereas, The General Practitioners have original contact with the great majority of all patients, and

Whereas, The people of the United States will be inclined to view with favor and good will the official recognition of their family physicians as a distinct part of the American Medical Association, and

Whereas, The specialty fields are overcrowded with general practitioners classified as specialists only because there is no proper classification for them, and

Whereas, The establishment of an official Section on General Practice in the AMA would stimulate a more active interest and co-operative attitude among the profession generally, making for greater unity in the advancement of the organization's programs, and

Whereas, The Council of the Wayne County Medical Society has gone on record as endorsing the introduction of these resolutions for the creation of a Section on General Practice of the AMA, and

Whereas, The Michigan State Medical Society has approved the resolutions looking toward the expansion of hospital staff privileges for General Practitioners throughout the country, therefore, be it

Resolved, That the House of Delegates of the American Medical Association take whatever action is proper at this time to create as soon as possible a new Section of General Practice to be duly constituted of equal rank and authority with the other sections already established and that the Delegates of the Michigan State Medical Society to the next American Medical Association Convention are hereby instructed to introduce this resolution to that body and that copies of this resolution be mailed to all American Medical Association Delegates.

THE SPEAKER: This resolution will be referred to the Reference Committee on Reports of the Council.

VI-2. SPECIAL MEMBERSHIPS

C. A. E. LUND, M.D. (Barry): The Barry County Medical Society, at its meeting of September 6, adopted the following resolution:

WHEREAS, Clarence P. Lathrop, M.D., of Hastings, has been in practice for fifty years and has been a member of the Michigan State Medical Society for twenty-five years, therefore, be it

RESOLVED, That the name of Clarence P. Lathrop, M.D., be presented to the House of Delegates of the Michigan State Medical Society for Emeritus Membership.

The Barry County Medical Society at its meeting of September 6 adopted the following resolution:

WHEREAS, Edgar T. Morris, M.D., of Nashville, has attained

the age of seventy years and has been a member of the Michigan State Medical Society for ten years, therefore, be it

RESOLVED, That the name of Edgar T. Morris, M.D., be presented to the House of Delegates for Life Membership in the Michigan State Medical Society.

THE SPEAKER: These resolutions will be referred to the Reference Committee on Officers' Reports.

VI-22. AMERICAN CANCER SOCIETY—MICHIGAN BRANCH

L. E. SEVEY, M.D. (Kent):

WHEREAS, it is the announced policy of the American Cancer Society to appoint as its Executive Committee in each state the Cancer Committee of the State Medical Society; and

WHEREAS, In recent years this has not been the case in the State of Michigan, therefore, be it

RESOLVED, That in order to secure a more comprehensive relationship between the Michigan State Medical Society and the American Cancer Society, Michigan Division, an urgent request be forwarded to the American Cancer Society that it appoint the medical members of the Executive Committee of its Michigan Branch from a list of physicians nominated by the Council of the Michigan State Medical Society.

THE SPEAKER: This resolution will be referred to the Reference Committee on Reports of the Council.

VI-23. AMA CONSTRUCTIVE PROGRAM OF MEDICAL CARE

R. M. ATHAY, M.D. (Wayne):

WHEREAS, The Board of Trustees and the Council on Medical Service and Public Relations of the American Medical Association have developed and promulgated a Fourteen-Point Program for Medical Care; and

WHEREAS, This excellent pattern offers to the nation a positive plan for voluntary health programs that is far superior to any offered the people of this country to date; therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society congratulate the Board of Trustees and the Council on Medical Service and Public Relations of the American Medical Association and offer them the entire support of the medical profession of Michigan in the furtherance of the Constructive Program for Medical Care; and be it further

RESOLVED, That the component and district medical societies in this state, and the individual members thereof, be urged to assume the important duty of integrating the AMA program in their own areas so far as it applies to them, and that each component county society be requested to reserve time at one of its early meetings for an analysis of the fourteen points in the AMA Constructive Program for Medical Care.

THE SPEAKER: That resolution will be referred to the Reference Committee on Reports of the Council.

VI-24. LICENSURE OF HOSPITAL PRESIDENTS

B. H. DOUGLAS, M.D. (Wayne):

WHEREAS, A great deal of difficulty has arisen in the matter of graduates in medicine from schools in states other than Michigan securing approval as residents in Michigan hospitals because of the present requirements of the State Board of Registration in Medicine and the Michigan State Board of Basic Sciences which are working undue hardships not only upon the graduates but more particularly upon the hospitals of the state, be it

RESOLVED, By the House of Delegates of the Michigan State Medical Society—

That the Michigan Board of Registration in Medicine and the Michigan Basic Science Board be requested to give consideration to the following provision, namely,

That graduates in medicine from Class A medical schools within the United States, but outside the state of Michigan, who may desire to serve as resident physicians in Michigan hospitals be required to present credentials whether for examination or reciprocity to the above-mentioned Michigan Boards and that such graduates then be allowed to become residents in Michigan Hospitals for one year during which time all necessary steps to complete permanent licensure in Michigan shall have been accomplished. Any graduate failing to qualify and complete registration and licensure within the year must discontinue further residency at once and until such time as he may complete his licensure, and further be it

RESOLVED, That the Michigan State Medical Society House of Delegates go on record that if the Michigan State Board of Registration in Medicine and the Michigan State Board of Basic Sciences through their legal advisers find that the laws governing their authority as now written will not allow such provision for resident physicians to be made, that it be the sentiment of the House of Delegates that such necessary amendments be sought to the respective laws that will allow of such procedure at the earliest possible moment.

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

VI-2. SPECIAL MEMBERSHIPS

G. H. WOOD, M.D. (Northern Michigan):

The Northern Michigan Medical Society recommends as a Member Emeritus in the Michigan State Medical Society, one of its most highly respected members, Willis Earle Chapman, M.D.

Dr. Chapman was born in 1867, graduated from the University of Michigan Medical School in 1894 and has faithfully and honorably carried on the practice of medicine since that time. He is a general practitioner and has supported and been a member of his Local and State Medical Societies since their organization.

THE SPEAKER: That resolution will be referred to the Reference Committee on Officers' Reports.

G. H. WOOD, M.D.: Will there be an opportunity to introduce another resolution tomorrow?

THE SPEAKER: Yes, there will be tomorrow morning.

VI-25. MEDICAL VETERANS' READJUSTMENT PROGRAM

R. C. PERKINS, M.D. (Bay):

WHEREAS, The sum of \$16,723.75 is now being held in trust as the total accumulation from the special assessment of \$5 levied by the 1944 House of Delegates of the Michigan State Medical Society for the MSMS Medical Veterans' Readjustment Program, including payment for the services of a full-time Councilor and Advisor on postwar adjustment, such as the problems of (a) relocation, (b) postgraduate education, (c) finances; and

WHEREAS, The services of Procurement and Assignment Service, together with those of the present Placement Bureau of the MSMS can and are adequately caring for the medical veterans' relocation problem; and

WHEREAS, The combined postgraduate program integrated by the Michigan State Medical Society, the medical schools of Michigan, and other teaching institutions is and will adequately handle the medical veteran's postgraduate needs; and

WHEREAS, The only probable problem of the medical veteran who returns to Michigan may be that of finances; and

WHEREAS, The present Medical Veterans' Readjustment Program Committee and the administrative personnel of the Michigan state Medical Society are able to handle this phase of the veteran's problem, therefore be it

RESOLVED, That a Councilor and Adviser for the MSMS Medical Veterans' Readjustment Program be not employed and thereby, through additional and unnecessary administrative costs, deplete the fund; and be it further

RESOLVED, That the trust fund be held in trust, as at present, and be used only for loan purposes to returning medical veterans, where needed.

VI-2. SPECIAL MEMBERSHIPS

LUTHER W. DAY, M.D. (Hillsdale):

WHEREAS, Dr. Kenneth Stuart has been a member in good standing of the Bay County Medical Society and the Michigan State Medical Society and who, because of protracted disability, has been prevented from continuing in active practice, therefore, be it

RESOLVED, That Dr. Stuart be granted an Associate Membership in the Michigan State Medical Society by the House of Delegates.

WHEREAS, Dr. William R. Ballard has practiced medicine for over fifty years and has been a member in good standing of the Bay County Medical Society and the Michigan State Medical Society for more than twenty-five years, therefore, be it

RESOLVED, That he be awarded Emeritus Membership in the Michigan State Medical Society by the House of Delegates.

THE SPEAKER: The first of these resolutions will be referred to the Reference Committee on Resolutions, and the other two to the Reference Committee on Officers' Reports.

VI-2. SPECIAL MEMBERSHIPS

LUTHER W. DAY, M.D. (Hillsdale):

WHEREAS, Dr. Charles T. Bower of the Hillsdale County Medical Society has been a member of that organization for more than ten years, and

WHEREAS, It has been certified by this County Society that he has retired from practice due to ill health, be it therefore

RESOLVED, That this House of Delegates of the Michigan State Medical Society transfer his name to the Retired Members' Roster.

THE SPEAKER: This resolution will be referred to the Reference Committee on Officers' Reports.

VI-26. PLEDGE CARDS

G. L. McCLELLAN, M.D. (Wayne):

WHEREAS, To date 1700 members or approximately 40 per cent of the membership of the Michigan State Medical Society have signed cards pledging non-co-operation with a system of political medicine, and

WHEREAS, The movement in Michigan antedated the similar movement by the American Association of Physicians and Surgeons, and

WHEREAS, A signing of such a pledge is completely legal and involves no personal liability, and

WHEREAS, Such signing is a demonstration of unity and would immeasurably strengthen the position of the State Medical Society in combating political medicine, be it

PROCEEDINGS OF HOUSE OF DELEGATES

RESOLVED, That the Council of the Michigan State Medical Society immediately take steps to contact all members of the Society who have not yet signed such a pledge, and be it further

RESOLVED, That the vital necessity of such co-operation be explained to them.

THE SPEAKER: This resolution will be referred to the Resolutions Committee, the Reference Committee on Resolutions.

VI—27. AMERICAN HEALTH CARE

R. H. PINO, M.D. (Wayne):

WHEREAS, By reason of their status in problems of health welfare of the people, Doctors of Medicine by and large are looked to, to maintain the best health interests of the people,

WHEREAS, The magnitude of therapeutics is constantly increasing and whereas schools of thought develop into teaching institutions about single therapeutic procedures,

WHEREAS, When such schools do develop they find it necessary to expand their concepts and procedures with ever-increasing additions,

WHEREAS, This necessarily creates a time in the history of every new or renewed therapeutic development when it advances against odds, unsatisfactory to its practitioners and the public alike,

WHEREAS, Such methods as they use should be evaluated by research and if found good, recognized and incorporated into the programs of the regular medical schools,

WHEREAS, The evolution of the regular university medical schools demonstrates that the old schools of medicine are made up by periodic amalgamation of separate schools of thought as represented in Allopathy and Homeopathy and even of medicine and surgery which at first developed separately,

WHEREAS, Therefore, the sum total of the history of health care gives us the experience of the past as perspective for the future upon which we ought to be able to advance by reasonable and planned laboratory procedure evaluating scientific problems through research, and other problems through conference,

WHEREAS, There is evidence that some groups of practitioners outside of the so-called regular schools of medicine as well as within are desirous of holding conferences looking to the incorporation of all proved procedures into one educational channel, thus planning health care and medical education on a basis commensurate with highest standards,

WHEREAS, Responsible leadership seems to be left to the County and State Societies if courageous action is to be taken in matters of new policy in American health care, therefore, be it

RESOLVED, That a commission of five members, or whatever number seems best, be named by the Michigan State Medical Society, including one representative from each of the two medical schools of the state, to study the problem involved, to confer with interested parties and groups, and to report their findings and recommendations to the next meeting of the House of Delegates in 1946.

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

VII. Reports of Standing Committees

THE SPEAKER: The next item of business is Reports of Standing Committees.

The following reports of Standing Committees, all of which appear in the Handbook for Delegates, will be referred to the Committee on Standing Committees:

1. Legislative Committee
2. Committee on Distribution of Medical Care
3. Representatives to Joint Committee on Health Education
4. Medical Legal Committee
5. Preventive Medicine Committee
6. Cancer Committee
7. Maternal Health Committee
8. Venereal Disease Control Committee
9. Tuberculosis Control Committee
10. Industrial Health Committee
11. Mental Hygiene Committee
12. Child Welfare Committee
13. Iodized Salt Committee
14. Committee on Heart and Degenerative Diseases
15. Committee on Postgraduate Medical Education
16. Public Relations Committee
17. Ethics Committee

VIII. Reports of Special Committees

THE SPEAKER: The next order of business then is the Reports of Special Committees.

The following reports of Special Committees, all of which appear in the Handbook for Delegates, will be referred to the Committee on Special Committees:

1. Committee on Nurses' Training Schools
2. Prelicensure Medical Education Committee
3. Radio Committee (scientific presentations)
4. Advisory Committee to Woman's Auxiliary
5. Professional Liaison Committee
6. Beaumont Memorial Committee

7. Postgraduate Foundation Committee
8. Joint Committee with State Bar on V.D. Control
9. Special Committee on Radio
10. Committee on Procurement & Assignment Service for Doctors of Medicine
11. Medical Veterans' Readjustment Program Committee
12. Drafting Committee on Legislation
13. Committee on Rheumatic Fever Control

Committee on Procurement and Assignment of M.D.'s. Reported on pages 91 and 92. Is there a supplemental report?

P. R. URMSTON, M.D. (Bay): I have no written report as a supplemental report. There has been quite a bit of talk tonight on retirement of physicians, so I want to give you the latest directive received September 15. As you know, the Government employees do not work on Saturday any more. Therefore, I could not get out a written report.

While the public has been demanding the return of the GIs, they are forgetting at the same time that the Medical Detachment of that organization, although not in active duty, requires full time, and they are not being returned with these men to take care of the increased population. While we have had a million men return home so far, very few doctors have been released. Therefore, the ratio of the doctor to the civilian population decreases.

The procedure is given in the Handbook of the Appeal Committee. We have sent in the names designated by each County Procurement and Assignment Committee to this Appeal Committee, with the exception of those specialists who are on this committee. The general practitioners are the ones we want home and the ones we want home first.

This Committee has been rather slow. We meet not very often, and when we send in these appeals it is a long while before they are returned to the Government Assignment Office. Then we forward them to the officer who made the inquiry in this country, and he must have his resignation from his Commanding Officer, and it is sent through military channels to the Surgeon General. A good many times he refers back to the Appeals Committee for more information, whether some doctor has moved in there or not, or whether they do not need any extra care.

About two weeks ago the Appeal Committee met with the Surgeons General of the Army and the Navy and the United States Public Health Service. This is the latest directive, received by telegram last Saturday:

"Army Medical Corps officers will be considered surplus and separated from the service if they have eighty points or are forty-eight years of age or over." Then in parentheses it says "except for specialists."

Now the specialists, if you notice in the Handbook, in the directive had much higher points. Those men are going to be retained, while they will release some.

If they entered on active duty prior to Pearl Harbor, prior to January 1, 1941, the specialists will be released. This means that the Surgeon General will release by January 1, 13,000 physicians, and an additional 17,000 by June, 1946.

"Further details will follow shortly from this office."

We are doing everything possible to get the return of the medical men to your communities, and your County Committees will co-operate. The process has been slow because up until now the needs of the Army and Navy and the Army of Occupation were not settled.

At the time the report in the Handbook was written, V-J Day had not arrived. If you noticed the paper tonight, General MacArthur says we will need only about 200,000 men to take care of the Pacific, and the others will be released. We may get the doctors home much quicker than we think.

I want you to bear with us, and with the help of all, we will be able to get our doctors home by July 1, 1946. Thank you.

THE SPEAKER: Dr. Urmston's supplemental report, his written report, and also the additional report of the Vice Chairman of the Committee which appears on page 92, will be referred to the Reference Committee on Special Committees.

Medical Veterans' Readjustment Program. This report is in the Council's Report and will be referred to the Reference Committee on Reports of the Council.

MSMS Drafting Panel. The report is in the Council's Report, and is referred to the Reference Committee on Reports of the Council.

Postwar Education Committee. There is no report in the Handbook. Is there a supplemental report?

Rheumatic Fever Control Committee. Report is in the Council's Report. Referred to the Reference Committee on Reports of the Council.

Contact Committee with Association of Welfare Boards and Boards of Supervisors. There is no report in the Handbook. Is there a supplemental report? (None)

That completes our work then for tonight, and the Chair will entertain a motion to adjourn.

(The meeting adjourned at ten-fifty o'clock.)

Tuesday Morning Session September 18, 1945

The meeting convened at ten-thirty o'clock, A.M., P. L. Ledwidge, M.D., the Speaker, presiding.

THE SPEAKER: Is the Chairman of the Credentials Committee ready to report?

J. J. O'MEARA, M.D.: Mr. Speaker, I hold in my hands certified credentials of over 40 per cent of the 116 delegates to

the Michigan State Medical Society, 50 per cent of whom are not from any one county.

THE SPEAKER: If there is no objection from the House, the report of the Credentials Chairman will be accepted as the roll call.

Is there any unfinished business?

Any new business?

If not, we will go on with the reports of the Reference Committees.

The first is the Reference Committee on Officers' Reports, Dr. Wenger.

IX. Reports of Reference Committees

IX—1. ON OFFICERS' REPORTS

IX—1 (a). SPEAKER'S ADDRESS

A. V. WENGER, M.D.: The first item in the Report of the Reference Committee on Officers' Reports is the Speaker's Address. The Committee wishes to express its appreciation of the amount of effort on the part of the Speaker in the collection of material and data in the preparation of his report.

We take particular note of his remarks relative to attitude of the people concerning public relations as they affect medical care.

We compliment him on the report and recommend its acceptance.

Mr. Speaker, I recommend the adoption of the report.

(The motion was seconded by R. A. Johnson, M.D., Wayne, and carried.)

IX—1 (b). PRESIDENT'S ADDRESS

A. V. WENGER, M.D.: The second item is the President's Address. Your Committee feels that President Brunk's recommendation of supervised education of the public on the problems of the distribution of medical care, and the desirability of full information relative to its prepayment should be heartily endorsed.

Mr. Speaker, I move the adoption of the report.

(The motion was seconded by W. W. Babcock, M.D., Wayne, and carried.)

IX—1 (c). DELEGATES TO AMA

The third item is the Report of the Delegates to the AMA. There was no formal report.

IX—1 (d). SPECIAL MEMBERSHIPS

The fourth item is a resolution by Dr. Catherwood on recommendation of the Council of Wayne County that Dr. Thomas B. Cooley, an Honor Member of Wayne County Society, be elected to Member Emeritus in Michigan State Medical Society, which is approved by your Committee.

Mr. Speaker, I move the adoption of the report.

(The motion was seconded by W. D. Barrett, Wayne, and carried.)

The fifth item is the resolution by Dr. Catherwood, on recommendation by the Council of Wayne County Medical Society, nominating J. Whitlock Gordon, M.D., for Retired Membership in the Michigan State Medical Society.

Your Committee approves the resolution and recommends transfer of Dr. Whitlock to the Retired Roster.

Mr. Speaker, I move the adoption of the report.

(The motion was seconded by R. V. Walker, Wayne, and carried.)

Resolution by Dr. Waters, on recommendation of St. Clair County Medical Society, nominating Duncan J. McCall, M.D., a member of the St. Clair County Medical Society, for Member Emeritus in the Michigan State Medical Society. Your Committee approves his transfer to the Member Emeritus Roster.

Mr. Speaker, I move the adoption of the report.

(The motion was seconded by Arch Walls, M.D., Wayne, and carried.)

Resolution by Dr. Waters, on recommendation of St. Clair County Medical Society, nominating William P. Derck, M.D., a member of St. Clair County Medical Society, for Membership Emeritus.

Your Committee approves the resolution and recommends the transfer of Dr. Derck to the Member Emeritus Roster.

Mr. Speaker, I move the adoption of the report.

(The motion was supported by W. D. Harm, M.D., Wayne, and carried.)

Resolution by Dr. Waters, on recommendation of St. Clair County Medical Society, nominating James A. Allridge, M.D., a member of the St. Clair County Medical Society, for Life Membership in the Michigan State Medical Society. Your Committee approves the resolution and recommends the transfer of Dr. Allridge to the Life Membership Roster.

Mr. Speaker, I move the adoption of the report.

(The motion was supported by R. A. Johnson, M.D., Wayne, and carried.)

Resolution by Dr. Waters, on recommendation of the St. Clair County Medical Society, nominating Albert L. Callery, M.D., a member of the St. Clair County Medical Society, for Life Membership in the Michigan State Medical Society.

Your Committee approves the resolution and recommends the transfer of Dr. Callery to the Life Membership Roster.

Mr. Speaker, I move the adoption of the report.

(The motion was seconded by C. S. Clarke, M.D., Jackson, and carried.)

IX—1 (e). MICHIGAN FOUNDATION FOR HEALTH EDUCATION

Resolution on Michigan Foundation for Medical and Health Education, introduced by Dr. Darling.

Your Committee approves the resolution and recommends its adoption.

Mr. Speaker, I move the adoption.

(The motion was seconded by E. G. Krieg, M.D., Wayne, and carried.)

IX—1 (f). RECOGNITION OF MICHIGAN MEDICAL MEN IN MILITARY SERVICE

Resolution concerning medical men in military service, introduced by Dr. Darling. Your Committee approves the resolution and recommends its adoption.

Mr. Speaker, I move the adoption of the report.

(The motion was seconded by T. G. Amos, M.D., Wayne, and carried.)

THE SPEAKER: Dr. Wenger, will you please read that last resolution?

A. V. WENGER, M.D.:

"Resolved, That the House of Delegates of the Michigan State Medical Society honor those of its members who have made the supreme sacrifice in World War II, by standing for a moment with bowed heads in their memory, and further by requesting the Council to list their names on an appropriate scroll which shall be displayed permanently at the headquarters of the Michigan State Medical Society."

THE SPEAKER: I am sure we all want to carry out the first part. Will you stand with bowed heads for a moment?

(The audience rose and stood for one moment in silent tribute to the members of the Michigan State Medical Society who made the supreme sacrifice.)

IX—1 (d). SPECIAL MEMBERSHIPS

A. V. WENGER, M.D.: Resolution by Dr. C. A. E. Lund on recommendation of Barry County Medical Society, nominating Clarence P. Lathrop, M.D., a member of the Barry County Medical Society, for Membership Emeritus.

Your Committee approves the resolution and recommends the transfer of Dr. Lathrop to Membership Emeritus Roster.

Mr. Speaker, I move the adoption of the report.

(The motion was seconded by W. J. Stapleton, M.D., Wayne, and carried.)

Resolution by C. A. E. Lund, M.D., a recommendation of Barry County Medical Society, nominating Edgar T. Morris, M.D., a member of the Barry County Medical Society, for Life Membership.

Your Committee approves the resolution and recommends the adoption.

Mr. Speaker, I move the adoption.

(The motion was seconded by J. A. Kasper, M.D., Wayne, and carried.)

Resolution by Dr. Wood on recommendation of Northern Michigan Medical Society, nominating Willis Earl Chapman, M.D., a member of the Northern Michigan Medical Society, for Membership Emeritus.

Your Committee approves the resolution and recommends the transfer of Dr. Chapman to the Membership Emeritus Roster.

I move the adoption of this recommendation.

(The motion was seconded by M. A. Darling, M.D., Wayne, and carried.)

Resolution by Dr. Perkins, on recommendation by Bay County Medical Society, nominating Kenneth Stuart, M.D., a member of the Bay County Medical Society, for Associate Membership in the Michigan State Medical Society.

Your Committee approves the resolution and recommends its adoption.

I move that it be adopted.

(The motion was seconded by R. A. Springer, M.D., St. Joseph, and carried.)

Resolution by Dr. Perkins on recommendation of Bay County Medical Society, nominating William R. Ballard, M.D., for Member Emeritus in the Michigan State Medical Society.

Your Committee approves the resolution and recommends its adoption.

I move its adoption.

(The motion was seconded by R. V. Walker, M.D., Wayne, and carried.)

Resolution by Dr. Day, on recommendation of Hillsdale County Medical Society, nominating Charles T. Bower, M.D., a member of the Hillsdale County Medical Society, for Retired Membership.

Your Committee approves the resolution and recommends its adoption.

Mr. Speaker, I move its adoption.

(The motion was seconded by T. G. Amos, M.D., Wayne, and carried.)

Mr. Speaker, I now move the adoption of the report as a whole.

(The motion was seconded by T. K. Gruber, M.D., Wayne, and carried.)

PROCEEDINGS OF HOUSE OF DELEGATES

IX-2. ON REPORTS OF THE COUNCIL

THE SPEAKER: The next is the Report of the Reference Committee on Reports of the Council, Dr. Hull.

IX-2 (a). REPORTS OF THE COUNCIL

L. W. HULL, M.D.: Mr. Speaker and Members of the House of Delegates: The Reference Committee on Reports of the Council approves the Annual Report of the Council. It commends the Council on its judicious expenditure of the Society's funds. The compliments of the Committee go to Dr. Wilfrid Haughey, Editor, for his untiring efforts in the publication of an excellent Journal despite wartime restrictions.

This Committee would like to say more about the various committees mentioned in the Council's report, in praise of their efforts and well-done work and feels that individual recognition is deserved, but time being of the essence, these committees will have to be content with the report of their efforts as contained in the Handbook.

I move that the printed portion of the report be accepted.

ARCH WALLS, M.D. (Wayne): I second the motion.

THE SPEAKER: This motion is to accept the part of The Council's Annual Report that is printed in the Handbook. Is there discussion?

(The motion was carried.)

L. W. HULL, M.D.: The Supplemental Report of the Council is approved with the deletion of the last sentence in paragraph 3, re MSMS Medical Veterans' Readjustment Program, "The medical veteran who returns to Michigan will find what he wants in postgraduate work waiting for him."

I move it be accepted.

THE SPEAKER: Is there a second to this motion? The motion is to accept the supplemental report with the deletion of the sentence that Dr. Hull just read.

R. V. WALKER, M.D. (Wayne): I second it.

(The motion was carried.)

IX-2 (b). PUBLIC RELATIONS

L. W. HULL, M.D.: The resolution presented by Dr. Candler, recommending that a Public Relations man with good newspaper connections be hired immediately, is approved.

I move that this be accepted.

(The motion was seconded by G. L. McClellan, M.D., Wayne, and carried.)

IX-2 (c). ENDORSING MICHIGAN MEDICAL SERVICE

The Committee approves the resolution of Dr. Harm re the endorsing of MMS by all members of MSMS.

I move that this be accepted.

(The motion was seconded by H. F. Dibble, M.D., Wayne, and carried.)

IX-2 (d). NATIONAL HEALTH CONGRESS

The Committee approves the resolution of Dr. Wenger in regard to the National Health Congress for the establishment of such a National Health Congress to include representatives of the medical, dental, hospital, nursing and pharmaceutical professions.

I move the acceptance of that.

(The motion was seconded by H. L. Morris, M.D., Wayne, and carried.)

IX-2 (e). MSMS DRAFTING COMMITTEE'S OUTLINE

The Committee asks for approval of Dr. Insley's resolution re Michigan State Medical Society's "Outline" developed by the Michigan State Medical Society Drafting Committee subject to approval of the "Outline" by the House of Delegates.

I move the acceptance of this resolution.

THE SPEAKER: Will you read that once more, Dr. Hull?

(Dr. Hull read the item again.)

THE SPEAKER: If the Chair may inject something in there, I don't believe that last statement changed it in any way, unless I misunderstand you. If it is accepted, it is approved by the House.

L. W. HULL, M.D.: I move the acceptance of this resolution.

(The motion was supported by R. A. Johnson, M.D., Wayne, and carried.)

IX-2 (f). GENERAL PRACTICE SECTION

L. W. HULL, M.D.: Approval of the resolution for the creation of a General Practice Section in the AMA as introduced by Dr. Walls, is asked. The Committee further suggests that a copy of the resolution be sent to all the County Medical Societies in the United States.

I move the adoption of this resolution.

C. F. BRUNK, M.D. (Wayne): I second it.

THE SPEAKER: Is there discussion?

H. A. LUCE, M.D. (Wayne): I would like to ask something about the expense of sending that to all of the County Medical Societies in the United States. Is there some other way of reducing that expense and labor?

L. W. HULL, M.D.: There has been some talk about the General Practice Section not being able to get its ideas out at the AMA in Chicago. A thing of this kind has to come from

the County Societies first. This would be a means of getting the County Societies to do something about it.

THE SPEAKER: The Speaker would like to ask Dr. Foster to give a word of explanation about the routine of some of these things at this time.

THE SECRETARY: I believe the resolution calls for a presentation of this to the Councils of the several State Medical Societies. They in turn give it to their delegates. Anything that goes to the delegates to the American Medical Association does not come from the County Medical Societies, but from the parent organization, the State Society.

There are nearly three thousand county medical societies in the United States, and sending this to three thousand county medical societies would entail an expense from which you would get little results, because after all, it has to go to the AMA delegates, and it can only go to them through the respective councils of the state societies.

R. A. JOHNSON, M.D. (Wayne): Precisely, it should go to every county medical society. This is not just a Wayne County problem, not just a Michigan State problem; the recognition of the general practitioner is a national issue. In my opinion, the fundamental body that considers these problems is the local medical society, the county medical society. This is something that they want. Why can't the Michigan State Medical Society show them the best way to achieve the goal we are all after?

T. K. GRUBER, M.D. (Wayne): I agree with Dr. Johnson. I believe some 67 per cent of the doctors in the United States belong to the general practitioner class. I don't think they have proper representation in the House of Delegates of the American Medical Association. I don't think they have proper representation in any of the things that organized medicine does.

I certainly believe that this should go to every county medical society in the United States, even if it does cost a little money to run off some 3,700 of these on mimeographed paper. It isn't going to be such an awful expense either. I think the general practitioner has a right to a hearing, and he has a right to have his problems brought before the medical profession.

W. B. HARM, M.D. (Wayne): As Chairman of the General Practice Section, whether you pass this or not, I can guarantee that every county medical society in the United States will get notice of this resolution. If you don't want to do it for us, we will do it ourselves. We have paid our dues, and we have had a lot of expense for other things in this State Society. A little matter of sending out 3,000 letters, which Dr. Foster estimates to be the number, should be a small matter to do for fifty per cent of your members.

The county society is where any initiation in the General Practice Section or any other pertinent business of medical organization originates. It is the county society that should be informed on these things. There has been some headway made during the past year on this general practice consideration. Work has been done in Cincinnati and in Kansas City, and we are doing everything to carry on.

THE SPEAKER: Is there any further discussion?

G. L. MCCLELLAN, M.D. (Wayne): Gentlemen, I think there is one very important point that has been overlooked, when we discuss a matter of this kind, and that is the political aspect of unifying medicine. If you are not going to have a united profession, if you are not going to give a large segment of your profession their just representation, you cannot have interest in medical problems.

The printing and postage would probably run about \$150, plus whatever the office expense might be of sending it out. It could even be sent out through the state societies, requesting that they in turn send it to their county societies. We could pay the postage and let them address it to their components, if they will. Certainly this measure should pass.

THE SPEAKER: Dr. Foster, will you comment on this suggestion?

THE SECRETARY: Mr. Speaker, Dr. McClellan has just brought up a point that solves the problem, for this reason: It is customary for state societies to deal with other state societies. We have recently had a number of communications from county societies over the country, which we do not recognize until we have consulted their state parent organization to make sure the matters have been approved.

I was going to suggest, before Dr. McClellan got up, that we prepare this and send it to the respective state societies, in stamped envelopes, and ask them if they will forward it to their mailing lists in addressograph sheets.

There is no objection to getting it to the county medical societies, but the point we are making is that the state societies have a rule whereby they do not respect the initial communication from the county without clearing it through the state.

I was going to make the same suggestion Dr. McClellan made, that this be prepared and sent to the forty-eight state secretaries, in stamped envelopes, with the request that they forward it to their constituents.

THE SPEAKER: We are ready for the question. Is the question understood by all, that the mechanism of sending will be as suggested by Dr. McClellan? Is that satisfactory to everyone?

T. K. GRUBER, M.D. (Wayne): Mr. Speaker, I move an amendment to the resolution which will embody that.

THE SPEAKER: Dr. Gruber moves an amendment which will embody that.

R. A. SPRINGER, M.D. (St. Joseph): I second the amendment.

THE SPEAKER: Is there discussion?

The amendment covers the point mentioned by Dr. McClellan, and as supported by Dr. Foster, as to the method of sending it, that these be prepared in the Michigan State Medical Society and the envelopes stamped and sent to the state societies for redistribution to their respective county medical societies.

Is there any discussion on the amendment? All in favor of

the amendment say "aye"; opposed. The amendment is carried.
We will now vote on the original motion as amended. Is there further discussion? If not, all in favor say "aye"; opposed, "no." The motion is carried.

IX—2 (g). AMERICAN CANCER SOCIETY, MICHIGAN BRANCH

L. W. HULL, M.D.: The Committee does not feel that it has enough information concerning the appointment of medical members from the State of Michigan to the American Cancer Society to approve or disapprove of the resolution submitted by Dr. Sevey, that the American Cancer Society appoint the medical members of its Michigan Branch from a list of physicians nominated by the Council of the Michigan State Medical Society.

Do you want me to read that again?

THE SPEAKER: Dr. Hull, you mean the Committee is not ready to make any recommendation, on it?

L. W. HULL, M.D.: The Committee hasn't enough information. We do not know how the members of the Michigan Branch of the American Cancer Society are appointed now. We don't know who they are.

THE SPEAKER: And the recommendation of the Committee is what?

L. W. HULL, M.D.: That the Michigan members of the American Cancer Society be appointed by the Council of the Michigan State Medical Society from a list given to the American Cancer Society by the Council of the Michigan State Medical Society.

THE SPEAKER: And what does the Committee propose to do with the report?

You see, Robert's Rules of Order, as I understand them, call for this: Once a matter has been referred to a committee, the committee recommends its position, until the committee is discharged. Does the committee have any recommendation to make as to what they want to do with the resolution?

L. W. HULL, M.D.: The Committee has no recommendation to make because the Committee does not have enough knowledge as to what the resolution means or how it is going to be worked out.

So the Committee asks and I move that the motion be tabled.

THE SPEAKER: The Chairman has moved that the motion be tabled. Is there a second to that motion?

M. A. DARLING, M.D. (Wayne): Second the motion.

THE SPEAKER: The motion is that the resolution be tabled. All in favor say "aye"; opposed. The motion is carried.

THE SPEAKER: Now with the permission of the House, I would like to refer to the resolution that has to do with the appointment of members from the Michigan State Medical Society to the American Cancer Society—Michigan Branch. I believe it was improperly handled. We would like to handle it properly. Do you care to make any motion on that now?

L. W. HULL, M.D.: I move that this resolution, re the Executive Committee of the American Cancer Society, Michigan Branch, be referred back to the Committee for further clarification.

(The motion was seconded by R. A. Johnson, M.D., Wayne.)

THE SPEAKER: The motion is that this resolution be referred to the Reference Committee on Reports of Council for further study and clarification on these points that are brought up. Is there discussion? All in favor say "aye"; opposed. The motion is carried.

L. W. HULL, M.D.: The Chairman thanks the members of the Committee on Reports of the Council for their very able assistance in making up this report.

I move the adoption of the report as a whole.

(The motion was seconded by W. B. Harm, M.D., Wayne, and carried.)

IX—3. REFERENCE COMMITTEE ON STANDING COMMITTEE REPORTS

THE SPEAKER: Next is the Report of the Reference Committee on Standing Committees.

L. W. GERSTNER, M.D.: The Committee on Reports of the Standing Committees approved the report of the Legislative Committee.

Mr. Speaker, I move that it be adopted.
(The motion was seconded by R. A. Johnson, M.D., Wayne, and carried.)

The Committee approved the report of the Committee on Distribution of Medical Care.

Mr. Speaker, I move its adoption.

The motion was seconded by T. G. Amos, M.D., Wayne, and carried.)

Mr. Speaker, the Committee recommends the adoption of the report of the Preventive Medicine Committee. Seconded and carried.

The Committee approves the report of the Maternal Health Committee.

Mr. Speaker, I move its adoption.

(The motion was seconded by C. F. Brunk, M.D., Wayne, and carried.)

The Committee approves the report of the Venereal Disease Control Committee, and I move its adoption.

(The motion was seconded by R. M. Athay, M.D., Wayne, and carried.)

The Committee approves the report of the Tuberculosis Control Commission. I move its adoption.

(The motion was seconded by L. W. Hull, M.D., Wayne, and carried.)

The Committee approves the report of the Industrial Health Committee. Mr. Speaker, I move the adoption.

(The motion was seconded by J. K. Bell, M.D., Wayne, and carried.)

The Committee recommends the adoption of the report of the Committee on Mental Hygiene. I move its adoption.

(The motion was seconded by T. G. Amos, M.D., Wayne, and carried.)

The Committee approves the Child Welfare Committee Report. I move its adoption.

(The motion was seconded by Arch Walls, M.D., Wayne, and carried.)

The Committee recommends the Iodized Salt Committee report. I move its adoption.

The motion was seconded by W. B. Harm, M.D., Detroit, and carried.)

The Committee recommends the report of the Committee on Heart and Degenerative Diseases. I move its adoption.

(The motion was seconded by T. G. Amos, M.D., Wayne, and carried.)

The committee recommends that we adopt the report of the Committee on Postgraduate Medical Education. I move its adoption.

(The motion was seconded by R. C. Perkins, M.D., Bay, and carried.)

The Committee recommends the adoption of the report of the Committee on Public Relations. I move its adoption.

(The motion was seconded by Arch Walls, M.D., Wayne, and carried.)

The Committee recommends the Report of the Committee on Ethics. Mr. Speaker, I move its adoption.

(The motion was seconded by L. W. Hull, M.D., Wayne, and carried.)

The Committee moves the adoption of the report of the Representatives to Joint Committee on Health Education and concurs in the recommendation that the Committee be dissolved.

Mr. Speaker, I move its adoption.

(The motion was seconded by R. A. Johnson, M.D., Wayne, and carried.)

The Committee moves to accept the report of the Medical Legal Committee and feels there is definite need of that particular committee.

Mr. Speaker, I move the adoption.

The motion was seconded by J. A. Kasper, M.D., Wayne, and carried.)

The Committee recommends the acceptance of the report of the Cancer Control Committee, with the exception that we recommend the deletion of paragraphs five and six.

It was the consensus of the Committee that cancer courses cannot adequately be presented to high-school age groups, due to their impressionable age and the difficulty of securing adequate or proper instruction.

Mr. Chairman, with that addition, I move the adoption.

THE SPEAKER: Will you read it once more?

(Dr. Gerstner read that item again.)

L. W. GERSTNER, M.D.: Paragraphs 5 and 6 are as follows: "5. That biology be made a required subject in all high schools and that teaching of cancer prevention and control be made a part of the regular health education training in high schools and colleges, but only under adequately trained teachers."

"6. Support a plan for discussing cancer in high schools under direction of competent medical authorities supplied by the Cancer Control Committee of the State Society."

It was the opinion of the Committee that the high school age group was not prepared emotionally to accept the teachings and instruction on cancer.

I move the adoption of the report.

THE SPEAKER: The motion is to accept the report of the Cancer Control Committee with the deletion which Dr. Gerstner has read.

(The motion was seconded by F. J. O'Donnell, M.D., Alpena, and carried.)

L. W. GERSTNER, M.D.: Mr. Speaker, we move the adoption of this report in its entirety.

(The motion was seconded by W. B. Harm, M.D., Wayne, and carried.)

THE SPEAKER: Thank you, Dr. Gerstner.

IX—4. ON REPORTS OF SPECIAL COMMITTEES

The next item of business is the Report of the Reference Committee on Special Committees.

R. H. PINO, M.D.: The Reference Committee has gone over all the reports as they are printed, and if it is all right to do so, we will just name these committees, except for those that we have some special mention to make of, and ask for the acceptance of them, rather than take them up separately.

Committee on Nurses' Training Schools

Committee on Procurement and Assignment Service for Doctors of Medicine

Conference Committee on Prelicensure and Medical Education

Radio Committee

Professional Liaison Committee

Beaumont Memorial Committee

Joint Committee with State Bar of Michigan on Venereal Disease Control.

We move the acceptance of these reports together.

I so move.

(E. A. Oakes, M.D., the Vice Speaker, took the chair.)

THE VICE SPEAKER: The motion has been made. Do I hear a second?

(The motion was seconded by B. G. Holtom, M.D., Calhoun.)

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B. H. DOUGLAS, M.D. (Wayne): I believe the Radio Committee report calls for dissolution of that Committee.

R. H. PINO, M.D.: I doubt that that was discussed. If so, it is in the report, and we move the acceptance of the report as it is.

THE VICE SPEAKER: With the deletion of the radio report, we will vote on the other ones at this time. All in favor signify by saying "aye"; opposed. The motion is carried.

R. H. PINO, M.D.: I move the adoption of the Radio Committee report.

(The motion was seconded by E. G. Krieg, M.D., Wayne, and carried.)

R. H. PINO, M.D.: Regarding the Postgraduate Foundation Committee, we commend the action of the Committee and wish to express the appreciation of the Society for the Committee's efforts and to the donors for their generous contributions and foresight. We recommend that the members of the Society read carefully this report.

We move the acceptance of this report.

(The motion was seconded by M. A. Darling, M.D., Wayne, and carried.)

Regarding the Special Committee on Radio, the Reference Committee realizes the extent to which this Committee has gone to provide a high class of publicity and entertainment which has required untiring effort. We feel this Committee should be highly commended for its work. We hope they will be given appropriate financial support and encouragement. "Let's keep it that way."

We move the acceptance of this report.

I so move.

(The motion was seconded by F. G. Buesser, M.D., Wayne.)

SPEAKER: Any discussion?

(The motion was carried.)

R. H. PINO, M.D.: Mr. Speaker, I move the adoption of these reports as a whole.

The motion was seconded by W. B. Harm, M.D., Wayne, and carried.

IX-5. ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

THE VICE SPEAKER: Has the Committee on Amendments to Constitution and By-laws anything to present?

L. W. DAY, M.D.: Mr. Speaker, this is probably the briefest report any Reference Committee on Amendments to the Constitution and By-laws has ever given.

Since there were no amendments referred to this Committee, there was no committee action.

Mr. Speaker, I move the adoption of this report.

(The motion was seconded by W. J. Stapleton, M.D., Wayne, and carried.)

IX-6. ON RESOLUTIONS

THE VICE SPEAKER: The Reference Committee on Resolutions, Dr. DeTar.

JOHN S. DETAR, M.D.: Mr. Speaker and Members of the House of Delegates: I have a number of resolutions which have been passed by the Reference Committee on Resolutions.

IX-6 (a). RE CHILDREN'S BUREAU

Resolution by Dr. Johnson pointing out the deficiencies of the Children's Bureau, and asking that the powers of this Bureau be confined to education and research, and not to include the practice of medicine.

"Whereas, The recommendations concerning Maternal and Infant Care adopted by the Steering Committee on Health Services, advisory to the United States Children's Bureau, United States Department of Labor, adopted January 28, 1945, would give the Children's Bureau almost unlimited powers, and

"Whereas, The recommendations would place the Bureau in the field of public health where it does not belong, and would place a large section of the practice of medicine under the domination of a lay-controlled bureau, and

"Whereas, The Children's Bureau has used World War II as an excuse to enlarge its powers on the basis of patriotism, and

"Whereas, The past practice of this body has been to issue directives affecting medical practice without consideration of the opinions of, or consultation with, practicing physicians, and

"Whereas, The Children's Bureau appears to be the experimental station for the piecemeal socialism of medical practice, leading eventually to socialization of the whole, therefore, be it

"Resolved, That the activities of the United States Children's Bureau be limited to education and research, and its powers be not increased to include control of the practice of medicine, in part or in whole; and be it further

"Resolved, That copies of this resolution be forwarded to the Secretary of Labor, the Chief of the Children's Bureau, to the Michigan members of Congress, to the members of the Congressional Committees which normally consider Maternal and Infant Care proposals, to the American Medical Association, and to the Secretary of every State Medical Society."

This resolution was approved by unanimous vote, and I, therefore, Mr. Speaker, move its adoption.

(The motion was seconded by L. W. Gerstner, M.D., Kalamazoo, and carried.)

IX-6 (b). UNIFORM FEE SCHEDULE FOR GOVERNMENT AGENCIES

This is a resolution regarding Uniform Fee Schedule for Government Agencies.

I had planned to ask Dr. Novy to give us some preliminary remarks, in order that you might understand the tremendous amount of work which has preceded the drawing up of this resolution. (The resolution was read.)

THE VICE SPEAKER: At this time we shall hear Dr. Novy.

R. L. NOVY, M.D. (Wayne): I am making this report or discussion because this problem is one of vital importance. It involves a step in a changed attitude of the profession.

The committee that had this under consideration was appointed by The Council of the State Medical Society, because The Council recognized that the changing times are such that recognition of the problem of wards of government is imperative. By wards of government, should be understood those categories, not only the welfare but also all those individuals who have been called wards of government. That does not mean an indigent, but it means an individual in whom the government has certain paternalistic interests. The returning veteran is the outstanding example of a ward of government. The government has given and will continue to give in larger measure certain prerogatives to that individual.

The veterans of the last war are wards of government. Any individual who was in the last war, who walks out of this room and falls down and breaks his leg, can go, at government expense, and be hospitalized and taken care of. He is not an indigent. He is a ward of Government.

Those categories are going to increase. The Council recognized that trend. It also recognized the trend that the existence of the welfare load has been with us and will be with us.

To that end, The Council appointed this committee to arrange for a uniform fee schedule to meet the inevitable problem that is coming, of a large proportion of the population that is either on the welfare or wards of government.

A change in philosophy of the medical profession has also occurred, along with the trends of the time. That change in philosophy on the part of the medical profession has changed from the point that anyone who does not have ready means, the doctor will take care of. That applied to a doctor in a small community who knew the indigents of his community, who called them by their first name, and who took care of them as part of his responsibility in the community.

At present, with our greater growth, we of necessity have outgrown that idea and at the present time, coming to your office may be a list of charity people sent you by some government agency, saying, "These people are welfare people; take care of them." You never heard of them. You will never see them again. They are not your charity. They are the charity of somebody else, and you are asked to take care of them.

I recall a comment along that line that Dr. Ballin made, and that I think applies very definitely here. A wealthy patient brought her sister to Dr. Ballin. The wealthy patient was in the millionaire class. Her sister was brought to Dr. Ballin for an operation. The wealthy sister said to Dr. Ballin, "Doctor, I know your fees are rather high. Won't you cut those fees, because my sister is poor?"

Dr. Ballin said, "This is your sister?"

"Yes."

"Do you recall an old saying, 'Charity begins at home?' My fee is so much."

I use that in saying that if the government agencies come to you and say, "Here is a charity patient; take care of him for charity," your reply is, "Charity begins at home, those who are looking after that welfare patient."

This committee was established and given the job of preparing a fee schedule which would be equitable, which would be the average fee that you would expect to charge an average patient. It is not intended as a charity fee schedule. It is not intended as an exorbitant fee schedule. It is intended that if the wards of government or the charity cases should increase so that you are forced to look after a thousand such little people—we use an extreme example—you will not only make the cost of your office but you will also make the cost of your livelihood in doing it.

Another point is that if the bricklayer is asked to build a poorhouse, or if he is asked to build a castle, or if he is asked to build an average man's home, he doesn't say to the Welfare Board, "You are putting up a poorhouse, and I will work on that on my off time," or "I will cut my fee in half to put up the poorhouse." He says, "I am going to pay taxes the same as everybody else, and it is a fair problem that I get my just wage."

That is the problem, and that is our philosophy.

Some of you may wish to cling to the ideal that has been present through many generations of medical men, that has been there forever, and let me say that is not encroached upon. Where you want to give charity, you can give charity, but where you

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MSMS PROPOSED UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES

	U.F.S.—G.A. Fee*	M.C.C.C. Fee**	Counties Above M.C.C.C. Fees		Counties Below M.C.C.C. Fees	
Appendectomy	\$ 75.00	\$50.00	Dickinson	\$75.00	Allegan	\$40.00
			Mason	75.00	Cass	40.00
					Clare	35.00
					Emmet	35.00
					Hillsdale	40.00
					Sanilac	45.00
					Van Buren	40.00
					Wayne	30.00
Herniotomy	75.00	50.00	Dickinson	56.25	Allegan	40.00
			Mason	75.00	Alpena	35.00
					Clare	35.00
					Clinton	35.00
					Emmet	35.00
					Sanilac	45.00
					Van Buren	40.00
					Wayne	30.00
					Gogebic	25.00
Tonsillectomy-Adenoidectomy	30.00	15.00	Alger	25.00	Allegan	10.00
			Dickinson	18.75	Barry	12.50
			Mason	20.00	Luce	12.50
			Tuscola	16.60	Wayne	10.00
Fracture of Femur	85.00	35.00	Bay	50.00	Allegan	30.00
			Dickinson	75.00	Alpena	25.00
			Iosco	50.00	Clinton	25.00
			Monroe	45.00	Gogebic	25.00
			Tuscola	50.00	Gd. Traverse	25.00
					Mason	25.00
					Newaygo	15.00
					Van Buren	30.00
					Wayne	30.00
Mastoid	100.00	50.00	Dickinson	75.00	Clare	35.00
			Tuscola	66.60	Emmet	35.00
					Gogebic	30.00
					Wayne	30.00
Obstetrical	40.00	25.00	Dickinson	26.25	Alger	15.00
			Tuscola	26.60	Antrim	15.00
			Iron	31.50	Arenac	15.00
					Branch	20.00
					Clinton	15.00
					Delta	15.00
					Gd. Traverse	15.00
					Huron	15.00
					Jackson	15.00
					Mason	20.00
					Mecosta	15.00
					Monroe	15.00
					Sanilac	15.00
					Wayne	10.00
Bedside Calls	4.00	2.00	Saginaw	3.00	Alger	1.00
					Clinton	1.50
					Delta	1.00
					Emmet	1.50
					Gogebic	1.00
					Luce	1.00
					Montcalm	1.00
					St. Clair	1.50
					Wayne	.75

*Proposed Uniform Fee Schedule for Governmental Agencies, MSMS.

**Michigan Crippled Children's Commission.

are dictated to, that you must give charity, that we object to. Your charity patients are yours, and the privilege of giving charity at any time is yours, but the problem of this Committee is not in that direction. It is towards the dictation of what shall be your charity, not your choice of what charity is.

The Committee went about developing this fee schedule. It was partly endorsed not only by The Council, that the problem should be undertaken, but we were also approached by various government agencies who dispensed welfare in various forms throughout the state. They are anxious that there be some uniform fee schedule established.

Among the various government agencies—Old Age, Crippled Children, Afflicted Adults, and so on, to say nothing of the Federal setup—there is a wide discrepancy in the fees that are paid, for a given procedure. There is wide discrepancy in the fees that are paid in geographic distributions. Those fees are dependent upon the mood of the particular county society, and some of those fees, in fact most of those fees, have not been changed since the depression days of '32.

(Slide) This information was given me by Dr. Carleton Dean of the Crippled Children's Commission, and to it is added the first column, but it is intended to illustrate the point of the wide discrepancy of fees in the various portions of the state.

The top is obstetrical fees. The fee set by this group, the Committee, was \$40. The fee paid by the Crippled Children's Commission is \$20 maximum, and the counties above that fee are named. Dickinson County charged \$26; Tuscola, \$26 and a fraction; Iron, \$31.

The counties below are also listed there at the extreme right, and you will see that it goes down to between \$10 and \$15. In

Wayne County, for instance, the bottom of the first bracket, \$10 is the allowed fee.

The bedside calls, which is the next item, allowable, Crippled Children's Commission, \$2. Set by our schedule, for reasons that we will not go into in detail, but all these various items have been gone into in detail, \$4. Above the two-dollars is Saginaw with a three-dollar fee, and below it are the counties that are indicated, with 75c for Wayne County, and you can't hire a taxi-driver to go any distance for 75c.

(Slide) This again applies to the same thing, the schedule that has been proposed, and the two columns on the right with the extreme setup there. You will notice that for appendectomies \$30 is paid in Wayne County, and yet in Dickinson County and in Mason County they are charging \$75 for that. Wayne County has \$30. I am mentioning Wayne County because I am from Wayne County. It is at the bottom of the list, and also in the bottom of the fees in a great many cases.

The next one shows a similar setup. You have Dickinson County and Mason County with a fee schedule that is somewhere near comparable to what it should be. Look at the other counties that run down the line.

I don't think I need to take that up. You can glance that over and see the drift of things. You will notice that it is possible for certain counties to maintain a proper rate if they go at it.

Dr. Christian called to my attention that in the Welfare Division the fee is paid half by the county, half by the state, and that whatever the county decides upon, the state is of necessity required to match it. The arrangement in that case is that the county board of welfare will take care of the fees set up in that particular county.

Some counties have set a fee schedule. Other counties are way down at the bottom and are taking almost nothing.

In going about the establishment of a fee schedule, there are a great many items that are necessary to be considered. The Veterans' Administration has a fee schedule with some four hundred-odd items. The Michigan Medical Service has a fee schedule of some three hundred-odd items. Those two schedules cannot be compared one with the other.

The Michigan Medical Service fee schedule is a bedrock schedule, with the statement that "This is bedrock, nothing less will be paid, but more will be paid, depending upon special circumstances."

The Veterans' Administration schedule is the roof over the house. They say, "Under no conditions will more be paid, and every effort should be made to get a lower fee." One is the basement of the house. The other is the roof of the house. They cannot be directly compared because the philosophy back of the two fee schedules is different.

We have those schedules to consider. In arranging for these fee schedules, there were fee schedules sent to all the different counties. There were fee schedules sent to all the specialists' societies. There were fee schedules sent to all the hospitals in Wayne because of the large number of doctors concentrated here. Not only were they sent to the hospitals, but they were sent to the various chiefs and departments—that is, the Obstetrical Department, and Nose and Throat Department, and so on, of each individual hospital. There were collected by this means a little better than 120 fee schedules.

In addition to that, we had, of course, the Veterans' fee schedule to look at. We have the Michigan Medical Service fee schedule to look at. All of those are fee schedules that were arbitrarily set up, on good judgment or bad judgment, but arbitrarily set up.

We had one other fee schedule that was not complete but in a few items was factual. That is the fee schedule that is the compilation of figures obtained from Genesee County. In Genesee County, because of the arrangements that are present, all the bills the doctor renders to any patient that comes under Michigan Medical Service have come to the Michigan Medical Service, and those have been compiled and averaged, so that we have in one county in the state some actual figures on the charges that doctors of that community have made. I believe nowhere else in the United States is such data available.

Those fee schedules were then compiled. They constitute somewhere around 25,000 items. They were added up. They were averaged. They were gone over by the Committee. Certain errors, certain misunderstandings in the arrangement, were deleted, and we arrived, after considerable time, at an itemized statement which is a fee schedule comprising close to 300 items in contrast to the size of 400 plus for the Veterans and 300 plus for the Michigan Medical Service. Many items, of course, appear in this that do not appear in either one or both of the others.

In arriving at those averages, every effort was made to be absolutely fair with the proposition. You will take exception to some of those items because of one reason or another.

The anesthetists mentioned that their fee schedule differed. That is true. Theirs did, but every county society replied on the anesthetists' fee and the anesthetists' fee as indicated by county societies was not, of course, the same amount as the specialists and anesthetists group had reported. That will apply to other and all individual items on this.

It is not the purpose of this meeting to discuss individual items. In the resolution presented there is provision for a thirty-day discussion before a committee of any objections to particular and specific items, and they can there be adjusted. What you have before you is the problem of the principle of establishing this and putting it into effect, not the handling of individual items as recommended here, as included in this schedule.

The problem of enforcing this fee schedule is a real problem, and it is a problem that requires the unanimous concerted action of every man in the Society. It is of no value to put in a fee schedule unless every man of the Society will stand back of it.

It is hoped that the justice of this fee schedule will be evident, and that you will stand back of it.

Remember this, it is still your prerogative, as it has always been, to say, "No, I will not do this job at this fee. My fee is something else." That applies now, when \$10 is paid in Wayne County for an obstetrical procedure. Any man in Wayne County can say, "No, I do not care to do that job at the fee paid, \$10."

This schedule is the same in that respect. You still can say, "No, my schedule is different. If you want me to do that, it will have to be a different schedule."

Unanimously, we should stand, that this is a fair schedule, and that no member of our group will countenance accepting from government agencies anything less than this.

I have here two volumes that represent the amount of work of this committee. This is all typewritten, through tabulation of page after page of these schedules, and it constitutes a volume of work, simmered down and made concise in the folder that you have. Thank you.

(P. L. Ledwidge, M.D., the Speaker, resumed the chair.)

JOHN S. DETAR, M.D.: Mr. Speaker and Members of the House: I move the adoption of this resolution.

R. L. NOVY, M.D. (Wayne): May I ask that the whole resolution be reread?

THE SPEAKER: Is that agreeable to the House? We will do that.

JOHN S. DETAR, M.D.: The resolution read as follows:

"WHEREAS, The physical restoration program and other medical services necessarily financed by government portend to be of vast proportions and great consequence particularly during the next few years, and

"WHEREAS, In the light of modern conditions, changes and trends, and the creation of vast new groups and categories, the

medical profession can hardly be expected to continue delivering its commodity of service to governmental agencies at less than cost, therefore be it

"RESOLVED, That hereafter the minimal fee for medical care of wards of government and indigents shall be commensurate with the work done, and be it further

"RESOLVED, That the fees in the Uniform Fee Schedule for Governmental Agencies, as developed by the Michigan State Medical Society, be considered the minimal fees for the service named, subject to revision in unusual cases—such unusual cases to be reviewed by a special board of doctors of medicine appointed by the Michigan State Medical Society, and be it further

"RESOLVED, That the Uniform Fee Schedule for Governmental Agencies of the Michigan State Medical Society be herewith adopted, subject to final approval by the Committee appointed by the Council which shall review and adjust any controversial items within the next thirty days; and be it further

"RESOLVED, That the Council of the Michigan State Medical Society is hereby authorized to declare the Uniform Fee Schedule for Governmental Agencies in effect and operative upon receipt and approval of the final report of the Committee appointed by the Council; and be it further

"RESOLVED, That the members of the Michigan medical profession stand united behind the Uniform Fee Schedule for Governmental Agencies, as developed and adopted by the Michigan State Medical Society, and be it finally—

The following is the paragraph which was stricken out by the Committee and another paragraph substituted for it. I will read the paragraph we have stricken out.

"RESOLVED, That the county and district medical societies of the Michigan State Medical Society make special efforts, immediately to negotiate necessary revisions in schedules of benefits governing governmental wards and indigents so that the medical profession is not penalized by being forced to perform services at a financial loss and below the fees indicated in the Uniform Fee Schedule for Governmental Agencies."

THE SPEAKER: That is the paragraph to be deleted?

JOHN S. DETAR, M.D.: The last paragraph. We recommend deletion of that paragraph and the substitution of the following paragraph:

"RESOLVED, That county and district medical societies immediately notify the various governmental agencies with whom they are in contact that the fee schedules of the Michigan State Medical Society will henceforth be in force as the minimum fee schedule for the care of governmental wards and for indigents, so that the medical profession may not be penalized by being forced to perform services at a financial loss."

It really is not a controversial matter. It is just a matter of implementing by making the wording a little stronger.

This resolution was passed not by unanimous vote, but by majority vote of seven to one.

I, therefore, move the adoption of this resolution as read, as amended.

THE SPEAKER: Is there a second to this motion?

W. B. HARM, M.D. (Wayne): I second the motion.

THE SPEAKER: Is there discussion?

G. H. WOOD, M.D. (Northern Michigan): I think that our approach to this problem is important, how we think about it and how we are going to carry on. I, for one, am not prepared to say that we have changed our philosophy. A philosophy is a set of principles, and principles are eternal. They do not change.

Dr. Novy has ably shown us that we have not in reality changed our philosophy, that our circumstances have been changed for us by other people. It is not a change of our philosophy. We still believe in doing charity work. As he says, he sees no reason why we will not continue to do charity work. What has changed is that government and public psychology have altered from giving the doctor credit for doing charity work to considering him a puppet to do everything that anybody wants to dump onto him.

Of course, as has been said here, we cannot work at a loss. What has happened is that instead of a doctor giving of his spare time to charity, we are now called upon to give a large part of our time to somebody else's plaything.

So, I hope that we will not confess that we have made a mistake in the past, and that we are changing our philosophy, that we did wrong in the past and now we are going to do the right thing, but that our principle has always been right and we have not changed it, and it is still right.

THE SPEAKER: Is there further discussion?

R. A. JOHNSON, M.D. (Wayne): I should like to read from the Handbook, on page 39, paragraph 2, "Uniform Fee Schedule for Governmental Agencies."

"At its February, 1945, meeting, the Executive Committee of the Council adopted the following resolution: 'In the light of modern conditions, changes, and trends, and the creation of new groups and categories—since in the past the medical profession has sold its commodity of service to governmental agencies at less than cost—that the minimal fee in the future shall be commensurate with the work done.' This action followed a discussion that the time seems to be here to withdraw the philosophy of a special discount rate to government for care of indigents and that this ideology must be changed before the profession can insist on a uniform fee schedule for governmental wards."

I heartily subscribe to that philosophy.

I think the method as outlined by Dr. Novy is bad. I think it is regimentation, self-sought.

After all, this principle of the care of the indigent is something that concerns localities. Hence, the variation in figures on that chart. Most decidedly, principles should be laid down and advocated by this body. Method is something else again.

I firmly believe that the democratic principle is this: that we work out the method to suit our own individual community needs. We know the people with whom we live and work. We know the

conditions under which we operate, and we can best obtain an adequate fee schedule for the care of the indigent with our own local group. After all, we are going to have to go back to them for this.

That brings up to me a very important point. I hate to see the word "fee" used for the care of the indigent. It has been the philosophy of medicine in the past to do the work on indigents free. We have been proud of the fact that we could do that. The day has now passed when that will be possible. There is too much of it. The doctor cannot afford, out of his pocket, to care for the indigent.

We all have a basic sum that is the cost per patient per day to be seen in our office. That includes the nurse, the rent, light, heat, car, insurance on the car, and so forth and so on. All those items come into what is the cost per patient per day.

I believe that we should be reimbursed for our cost in the care of the indigent, no matter whether they are from the city or the county or the state or the federal government. We should not get more than cost. If we do, we are accepting a fee. We say it is a minimum fee. We say it is a bedrock. We say it is a floor. Some of these figures here outlined are more than that, in my opinion.

I will illustrate that by this analogy. I think an income of \$100 a month would make an individual indigent in Wayne County. I know of a couple of counties in Michigan where a man can get by on that income and be self-supporting. He can pay his adequate medical expenses on that.

This scheme of having uniform fees does not take that principle into account. It, in my opinion, would wreck our chances of ever obtaining from any agency the type of fees that have been outlined. Thank you.

THE SPEAKER: Is there further discussion?

R. H. DENHAM, M.D. (Kent): I would like to explain why there was a dissenting vote in the Committee.

I have always subscribed to the idea of the physician doing his own charity. Dr. Novy speaks of the group turning into a single man to do group charity. It shouldn't be that way. They should go to their own physician. When they are distributed to their own physicians, it will not work a hardship on anyone.

If we are not careful in adopting this plan and the fee schedule that we all agree to live up to, we may be considered a trust of tradesmen, as we were in the courts in Washington, D. C. If we are going to back that up with an organization not unlike the unions of our workmen, and say, "We will strike, we won't do it as a group unless we are paid this fee," we are liable to be considered a trust of tradesmen.

I still believe that the doctor should give charity to his own patients that come to him or are referred to him by the doctors who commonly refer paying patients to him. I don't know how we are ever going to enforce this schedule.

W. B. HARM, M.D. (Wayne): Since the depression there has been a big change in the economic situation in medicine and everywhere else, in other fields in the country. The government at that time took over most of the charity, and took it over on a taxation basis.

Today, in Detroit, I don't know of a charitable hospital, and I don't know one in the state of Michigan. Every patient in a hospital bed is paid for in some manner, as far as I know.

The EMIC program is typical of these wards of government. As an example of what happens when the doctor does things for charitable patients, I would like to point out that at one hospital at Ann Arbor there is no fee charged by the physician for the care of these cases. However, that is made up by the Children's Bureau, paying that hospital \$9 per day per bed, where other hospitals throughout the state only get \$8.

At one hospital in Detroit, the physicians do not charge, and these patients are sent in through the outpatient department. There is no charge made for these patients. They get excellent care, and that hospital in turn is subsidized to the extent of \$9.80 a day, where other hospitals only get \$8. That \$1.80 is a fee that the doctor refused to accept. It is given to the hospital instead of the doctor.

I do not mind taking care of patients on a charitable basis, when I have the right to judge whether they are charitable cases or not, but today we are not the judge of who is on a charity basis.

The government has hundreds and thousands of social workers and case planners, traveling around the country, telling people that they are not able to pay for things. They do not ask you and me to judge whether they are able to pay. They do not ask you and me to judge whether they are able to part-pay. They tell these people they are entitled to free care, and they send them to your office to be cared for free.

Now if the government can afford to pay social workers \$150 to \$300 a month to go out and hunt up people and tell them that they are entitled to free care, it certainly can afford to pay you and me something for our services.

There is not a bit of doubt but this is a step toward socialized medicine, but the first three or four steps in socialized medicine have already been taken. The big danger of this whole program is whether it sets up a scheme of socialized medicine, but maybe it would be better to be prepared for it, under such a scheme, where we have something to say about it, and use a united front to speak our piece, than it would be to lie low.

C. F. BRUNK, M.D. (Wayne): I have a question. Are government wards indigent patients?

THE SPEAKER: I would like to have Dr. Novy answer that, if he will.

R. L. NOVY, M.D. (Wayne): The government takes care of indigent patients. Your problem is: Is a patient who is taken care of by the government an indigent? The government takes care of all indigents nowadays. Therefore, there are no indigents. They are all wards of the government.

P. H. ENGLE, M.D. (Eaton): Should this include some bor-

derline organization, such as Soldiers and Sailors Relief and Red Cross work?

THE SPEAKER: The question is, Should this include such organizations as Soldiers and Sailors Relief and Red Cross work? Dr. Novy, would you care to answer that?

R. L. NOVY, M.D.: Yes.

L. G. CHRISTIAN, M.D. (Ingham): Since 1939, I have had the privilege of being the medical representative of the Social Welfare Commission of the state. Before this House, on at least two occasions, I have said that the medical welfare situation in Michigan is in a chaotic state, and I repeat it.

Dr. Novy showed you that in Dickinson County, Iron Mountain and Crystal Falls, the doctors are getting \$75 for appendectomies, and they are getting \$3 for house calls and \$5 for night calls. That came about just a year ago.

As Dr. Novy said, it is up to the individual county, and it is up to the individual medical society to negotiate with its local welfare board.

When Dickinson County Medical Society approached its board and sold them the idea, they were afraid to go along, and they came to the State Commission and said, "May we do this?"

The State Commission has nothing to do with setting the fees in the individual county. The law simply says that we shall match fifty-fifty on medical care, and the other things that are needed by the welfare client.

There is something more to be done than merely raise your fees. For this body to say that it will set a certain uniform fee schedule is not enough. It appears to me that you are going to have to do a lot of missionary work and sell the local county the idea of coming up to that point.

There are a couple of federal categories for relief that have no provision for medical care. Your Old Age Assistance Group in this state at the present time has about 90,000, and these old folks need medical care. The Social Security Board has made no provision for that. We give them an extra grant, the worker will see them, and they say they must see the doctor, and we can give them a grant up to \$8 per month as long as that patient needs medical care. You fellows all sign these blanks—Mrs. Jones, what is your diagnosis, and what is the cost of medical care, so that the worker can allocate so much money to them.

The cost of medical care—that is the fee received by the doctor—has not changed in about 90 per cent of the counties since the days of the ERA. At that time they did office calls for 75c and a dollar. After you traveled three miles from your office you could charge them 25c a mile. The thing is a headache for the County Welfare Board, and they are asking for guidance.

About half a year ago I asked the field men of the Employees' Commission to make a medical survey of the various counties. Reading that report, you realize that there is no uniformity as to how a patient can get medical care. Sometimes they have to see the worker, and in some counties now they allow them to consult the physician of their choice for one call, and then they must report.

I would like to see something done.

I am not talking about whether this fee schedule is right, or whether it is wrong, whether it is enough or too much, but something should be done to make a uniform standard. Then we could go to the Legislature with some degree of accuracy and say to them, "Your welfare costs this year are going to be so much."

We know about how many people are ill on the welfare load. We cannot estimate at this time what it is going to cost the people of Michigan to furnish medical care for those welfare people. Many of them are denied medical care, and I fear that many more will be denied, but if you can make a uniform fee schedule, then you can accurately, or more accurately than we do now, estimate the cost of medical welfare.

The Aid to Dependent Children is another federal category for which there is absolutely no provision for medical care. Many of the counties have supplemented these people, taking it from the county and state funds for the medical care of these people, as they have done with the Old Age Assistance. But this isn't going to work unless the doctors in Cheboygan and Ingham and Bay and Ogemaw get behind it and approach their local welfare boards.

Dr. Novy, as I see it, the biggest job is to sell the doctor. If you can sell the doctor, I have confidence that you can sell the governmental agencies.

THE SPEAKER: Is there further discussion?

W. B. HARM, M.D. (Wayne): I just want to say one word to comment on Dr. Christian's remarks. I notice he said that when he wanted some information he asked the field men to go out; he didn't ask the doctors.

R. H. DENHAM, M.D. (Kent): I would like to make one more statement. We spent the morning planning government subsidy of medicine. We will spend the balance of the day making plans to resist government subsidy of medicine. It does seem that we are quite inconsistent.

A. B. SMITH, M.D. (Kent): I would like to take issue with that philosophy, Dr. Denham. I don't think we are doing any such thing, if you will pardon me. I don't believe this fee schedule in any way alters the situation so far as our practice is concerned in reference to government wards. We have had for a number of years experience with the treatment of wards of government, with the Crippled Children's Commission, the Afflicted Children, Afflicted Adults, and so on. We have not had for that service an adequate return. We have had what all of us would be willing to call a gratuity. In some instances the schedule amounts to nothing more than a tip for what you do for your patient.

This schedule is not going to increase the amount of work that you do for government. We are going to have government work whether we like it or not. We cannot avoid it. The ques-

tion is: If we do it, shall we receive an adequate, fair, compensation for the service that we render?

We are not inviting state medicine. We have state medicine in these categories. Whether we like it or not, the state is going to take care of its wards medically. They will hire somebody to do it for them if we don't do it.

I wish to pay tribute to the leadership Dr. Novy has given this Committee. It was referred to in one of our brochures as a monumental task, and it literally was that, the evaluation of 30,000 odd items, coming from 121 different schedules, emanating from every section of the state of Michigan. This fee schedule is not a guess job. It is an actual, mechanically factual, infallible average of the fees that the doctors in the state charge or hope to charge for the work they do, and in many instances the schedule provides a little above the average for their private practice. In other sections of the state it is a little below, but the average is fair. Always bear in mind that every item in the schedule is minimum.

The Veterans' Administration schedule says, "We will pay so much." That is the maximum. This schedule said, "We will pay so much plus." It is minimum. It is an elastic schedule, and it is comprehensive. It covers every possible service, so far as we can tell, that can be rendered by the medical profession to the public in every category.

The attempt to sell this idea reminds me of the man who tried to sell a ten-dollar gold piece for fifty cents. The average increase in income to the average physician in the state of Michigan, for work that he is now doing and that he will continue to do, willy-nilly, will approximately amount to 40 per cent. Thank you, Mr. Speaker.

B. G. HOLCOM, M.D. (Calhoun): I would like to add just one word. How many of you want to go back to the ERA period? During that time we made a survey of this affair in Calhoun County, and we found that about 41 per cent of the work that we were doing was work done for nothing, or for a pittance—the relief work, the ERA work and so forth. We also found that we had to deal with 31 different agencies in taking care of the poor or the wards of government.

This proposal gives us some pay for doing that work. They are wards of government. They are supported by taxation. The government can get money through taxation to buy food and clothing and housing for these people. Why not also pay their medical services?

The conditions are good right now. We may be able to get this program across now. How many of you believe that we are going to have another depression? If we are, do you want to go back to the old ERA?

R. J. ARMSTRONG, M.D. (Kalamazoo): When this proposal of The Council came before us, I think every doctor in Michigan greeted it with a welcome hand. I can't resist the tendency to feel a little bit practical about it, however. I hope that every one of you delegates from out in the state, who is going back to your county society, is going back with open eyes. I hope every one of you has looked over the schedule and asked himself whether he can endorse such a schedule.

I think it is absolutely impractical. The principle is absolutely right, and we ought to accept the principle and readjust the schedule.

I have great fear of leaving this committee with a power, after thirty days, to ask for enforcement of this schedule.

Those who have spoken in favor of it admit that it represents approximately the average fees for your average case. I do not believe we can ever force the counties in Michigan to pay such fees. I think we are separating ideas that won't be separated.

When we are thinking of wards of government, many of whom are self-supporting and able to pay their bills and yet are wards, and is on one side of the ledger. When we are thinking in terms of indigents, that is on the other side of the ledger. If we try to adopt a uniform fee schedule for all these patients on the basis of our average fees, we will not get enforcement. I do not think you can sell it to all the delegates here, and I know you cannot sell it to your physicians at home. How can we ever sell it to our welfare boards in these counties that have held us down?

I am not speaking of going back with ERA. We agree with the principle, but let's be a little bit practical. My plea is for some action that will require a readjustment of this fee schedule to a lower level before we ask all governmental agencies to pay such fees.

THE SPEAKER: Is there further discussion?

M. A. DARLING, M.D. (Wayne): Just one point of clarification. On page 40, paragraph 3, it speaks of "the United States Veterans' Administration has for some time been circularizing hospitals with a form of contract" for the care of veterans. That is true, and at least one, and I believe other of the larger hospitals of this community have already signed that agreement. If this passes the House of Delegates, I believe that the doctors of that particular hospital would be very glad to subscribe to this, but it should be understood that we believe in the validity of a contract and we cannot be held binding until the expiration of the present contract.

L. G. CHRISTIAN, M.D. (Ingham): Just a comment on Dr. Armstrong's statement that it cannot be done. He has no more information that it cannot be done, than Dr. Novy and I, who say that it might be done, or at least we can try to do it.

I do know that in a few counties where the doctors approached the problem with their local welfare board they did get a raise. I do know that in Dickinson County, which at one time had forty per cent of its residents on relief, and it is not a rich county—the valuation is not half as much as one ward of Detroit—they did get a fee schedule that favorably compares with the one that is proposed. They get \$3 for a house call in the daytime and \$5 at night, and they get \$75 for appendectomies and \$25 for

tonsillectomies, and they get the highest fee in the state for their obstetrics.

Maybe it can't be done, but it has been done to a certain extent in those counties where the doctors made the effort.

Repeating what I said, sell your doctor and you may sell this program.

R. A. JOHNSON, M.D. (Wayne): I refuse to be placed in the position of defending low fees. I do feel that the principle of charging the average fee throughout the state for self-supporting individuals to apply to indigents is wrong. Certainly the idea of 75c for an office call is ridiculous. It isn't even a tip. Nobody is trying to defend that. We do feel there should be an adjustment upward of that fee. But should the indigent patient be charged the uniform fee that is paid by self-supporting people? I say, No.

G. H. WOOD, M.D. (Northern Michigan): Dr. Armstrong has brought out a question which really I think is not only practical but enters into the philosophy of the problem. As the last speaker said, treating an indigent is a different proposition from treating people who normally would pay for their own treatment.

There is a difference between the poor, who are treated by the Welfare Board, and these other patients who are brought in as wards of the government under various pretexts.

I know from personal experience, and I don't doubt that many of you, if not all of you, know from your own experience that the welfare directors have a headache and they complain about the number of people who try to put it over on them and make them give them treatment, at county expense, at public expense, when the welfare director himself doesn't really think they are entitled to it. That is the practical side of it.

If we adopt a uniform schedule for both the poor and the wards of the nation who are not poor, we are going to dump a load on the welfare directors, and we are going to have their antagonism. If, on the other hand, we can do something to show them that we sympathize with them in their problems, we will have their co-operation. It seems to me that the principle is fair because the poor are a different proposition from those who should be able to pay.

Here is the point I want to make. I don't know how difficult it would be, but it seems to me that if we could work out a plan to give the poor board a percentage under this, or make this schedule for the poor boards and make a schedule for other wards higher—in other words, give a different level for the welfare boards—we would be right in principle and we would gain a great deal of co-operation from the poor administrations.

S. W. INSLEY, M.D., (Wayne): May I ask for clarification from Dr. Novy? I understand these figures were arrived at from averages gotten from various types of medical care. Were not your averages obtained from various fee schedules of all the governmental boards?

R. L. NOVY, M.D. (Wayne): These averages were obtained from the fee schedules of the doctors of the state of Michigan. We did look at the fee schedules of government agencies to see whereby they were different.

S. W. INSLEY, M.D.: The average does include ours?

R. L. NOVY, M.D.: Ours is the bottom. Theirs is the top.

S. W. INSLEY, M.D.: Did you include in that private practice?

R. L. NOVY, M.D.: What do you mean by private practice?

S. W. INSLEY, M.D.: Somebody intimated the private patients.

R. L. NOVY, M.D.: We took the fee schedules as sent to us and used that as a basis.

THE SPEAKER: Dr. Novy, may I ask you a question? I perhaps got a different slant on what Dr. Insley means than you did. I think, if I understood it correctly, Dr. Insley means this: Does this fee schedule as set up include only wards of government and other categories exclusive of private patients who are able to pay their own way, or are the private patients who are able to pay their own way also included?

Is that your question, Dr. Insley?

S. W. INSLEY, M.D.: Yes.

R. L. NOVY, M.D.: Private patients have nothing to do with this.

THE SPEAKER: In other words, they are all wards of government.

R. L. NOVY, M.D.: Categories comparable to wards of government. The private patient has nothing to do with this. Furthermore, if you don't care to take wards of government in your practice you can also decline that. Furthermore, if you want to take a ward of government, and notify the agency that because of your higher qualifications in that field you will expect more, you are entitled to do that.

S. L. LOUPEE, M.D. (Cass): I want to ask Dr. Novy one further question. Dr. Insley's question has not been answered.

R. L. NOVY, M.D.: I don't understand it, then.

S. L. LOUPEE, M.D.: I think you do not. I think it is this: In arriving at this average, did your Committee consider in these 25,000 or 26,000 items the fees which were submitted by private practitioners, or did you consider only the fees which are now paid by wards of government?

R. L. NOVY, M.D.: We paid no attention to the fees paid by wards of government.

S. L. LOUPEE, M.D.: You paid no attention to them? This is all private?

R. L. NOVY, M.D.: These are the fees that you, as members of the Medical Society, submitted. We had 121 and 122 fee schedules, and from those fee schedules this was made up. Those fee schedules were derived from county societies, from specialists' societies, and hospital staffs, and from breakdown of hospital staffs. They were compiled and averaged, and your schedule comes there as a final result.

THE SPEAKER: But, Dr. Novy, there is one other point you answered once before. In considering the schedules, you did not, if I understand you correctly, take into consideration the fees

charged private patients by private physicians—or did you?

R. L. NOVY, M.D.: We took the schedules.

THE SPEAKER: I mean those who come in and pay their own way.

R. L. NOVY, M.D.: I don't know what those men paid. I don't know a thing about it, barring one exception, and that was the one exception that I invited to your attention. In the case of Genesee County we have actual data over several years as to just exactly what they had charged each and every patient, and that was available to look at.

THE SPEAKER: Was that included in your average?

R. L. NOVY, M.D.: No.

THE SPEAKER: Does that answer your question, Dr. Insley and Dr. Loupee?

S. L. INSLEY, M.D. (Wayne): I think it does.

THE SPEAKER: Does it answer your question, Dr. Loupee?

S. L. LOUPEE: Yes.

R. C. PERKINS, M.D. (Bay): I have listened with considerable interest, as we all have, to this discussion. May I again refer to Dr. Insley's question as to whether, as I understood it, they took into consideration the fees charged by the individual doctor to the members of his practice. Dr. Novy says that they did not take into consideration the fees charged by private physicians in their own private practice.

This fee schedule, as Dr. Novy says, was made up from the fee schedules of the various county societies. Practically every county society in the state has a fee schedule which it has adopted. Otherwise it is a fee schedule charged by the individual member of that particular county society to his individual patients. To my notion, in that respect, the fee charged by the practitioner has been taken into consideration. The fee has been taken, it is true, as a group of private practitioners, but nevertheless it has been included in this final fee schedule.

Incidentally, if I may be permitted to take a little more time, I can see that there are still many who desire, shall we say, to do their own charity. This does not prevent them from doing their own charitable practice.

All of us remember the time of the ERA. Bay County was one of the societies that, even long before the ERA, had fights with county supervisors over fees. Under the ERA, if any practitioner devoted his entire time to the taking care of indigent patients, he could not make expenses. Perhaps he thought he did, but at \$1 or 75c for an office call he was not paying expenses. He was taking his time away from patients who paid a better fee, in taking care, as someone has said, of indigents whom he never saw in his office before and he has never seen in his office since. If he didn't take it out of them, he took it out of himself.

R. L. NOVY, M.D. (Wayne): On factual data on what you charge your patients, the average is not available, except as I mentioned. You yourself don't know what the average charge is, or very few of you know. You have never taken together 100 tonsillectomies and averaged up what you charge and gotten an average fee. You don't know what your average fee is.

I have before me here 2,000 tonsillectomies that were done in Genesee County. The average for those 2,000 tonsillectomies, for which we have the bills rendered to private patients, was \$30.42.

The fee schedule that we are contemplating provides \$30 for the tonsillectomy.

I do not want to go into the detail of itemized things at this time. We are talking principles. We have a committee to handle any discrepancies, but here are some factual statements as to what one county charged its private patients and all patients, over 2,000 cases of tonsillectomies, and it varies by 42 cents from the fee schedule we adopted.

S. L. INSLEY, M.D. (Wayne): May I clarify my position? I am thoroughly in accord with both the logic and the philosophy of this program proposed by Dr. Novy. I want to make that clear.

I want to make a further statement to clarify the quibbling about the indigent and the government. These indigents are taken care of under several categories, from public welfare funds, from the Afflicted Adults or Afflicted Children's Funds. They are taken care of from veterans' funds. There are a great number of sources from which these indigents may be paid for.

I think we are quibbling when we try to make a distinction between the indigent and the nonindigent.

R. H. BAKER, M.D. (Oakland): In listening to the discussion, it seems that many delegates feel that the fee schedule is too high for the welfare load. I wonder if they have taken into consideration the proportional costs of the welfare load.

In Oakland County in 1944 there was spent over \$225,000 for welfare care or social security. Of that amount only \$4,000 was paid to the doctors of Oakland County.

Oakland County possibly has not the best schedule of fees in the state, but we have one of the better ones. Therefore, when it was found that there was such a disproportion between the amount that was paid to the doctor and the amount that was actually spent, the members of the Welfare Board in Oakland County were very much chagrined and definitely stated to us that they felt they ought to at least pay what the doctor charges normally, because of that very small amount over the total cost, and for the past six or seven months, in Oakland County we have been waiting for the adoption of this fee schedule that you now have under consideration.

W. B. COOKSEY, M.D. (Wayne): I would like to ask Dr. Novy if I am not clear about the compilation of this schedule. I thought I had it clear.

A few months ago, at one of the hospitals where I serve, I was given a few sheets of this type. It had the same heading, "A Proposed Uniform Fee Schedule for Government Agencies," and I was asked to fill in what I thought was a fair fee for my department in that hospital.

At the same time, I think, Dr. Novy, you put on our desk what were my thoughts on uniform fee schedules for electrocardiography for government agencies. I okeyed or added or detracted to those as my judgment led me to do.

Is that not in these 25,000 items?

R. L. NOVY, M.D.: Yes.

W. B. COOKSEY, M.D.: Then it means that the practitioners of the state of Michigan, knowingly, give a set of figures not for their private practice but for this specific purpose, and that comprises a very large part of the average figures which you have compiled.

Is that an accurate statement?

R. L. NOVY, M.D.: That is not quite an accurate statement.

In the first place, I didn't put it on your desk. I did not distribute personally or directly, any of these fee schedules. I distributed them to official individuals, county societies and otherwise, and not to individuals.

There was sent to your hospital, to the chief of surgery, to the chief of medicine, to the chief of this and that, and, to all the county societies, a letter, specifying what it was, and he was asked to contact and in the light of that letter return the schedule. What he said to you, I do not know.

G. L. McCLELLAN, M.D. (Wayne): I sat in on one of the committee hearings on this matter, in one of the hospitals in Detroit, and from one of the specialty groups, the figures that were given at that meeting were presumably the figures which these men said they received for the care of their private patients.

I will state here that I question very, very much whether some of those men got from 90 per cent of their patients, or from 50 per cent of their patients, the prices they gave, and which entered into this compilation.

At no time in this meeting in which I sat was there any question whatever of indigent price. It was the price that they were receiving from their private patients that was considered and which they incorporated in the figures they sent to Dr. Novy's committee.

W. H. HURON, M.D. (Dickinson): There has been a great deal said about Dickinson County here, as having a rather high fee schedule for so-called indigent cases.

I would like to answer Dr. Armstrong, in saying that it can be done. We do not consider welfare cases, cases that are taken care of as wards of government, paid for by government agencies, as being indigent cases. If a patient comes into my office and he is not taken care of by a government agency, and I feel that his wage category is such that he cannot pay a reasonable fee, I am perfectly willing to go ahead and take care of him as a private patient and collect from him what I think he can pay. However, as soon as he goes on the government and is being paid for by the government, he no longer is an indigent case. Those cases are government cases and are paid for very willingly by our Welfare Board at a fee that is comparable to our regular fee schedule.

I am going to ask Dr. Foster to clarify that point just a little further.

THE SECRETARY: When The Council entered into this activity which Dr. Novy headed up, it realized that there were certain governmental categories of people who were and would be thrust upon you without your having anything to say about their determination. It is not a question of indigency. It was not a question of any one group. It is a question of all of these governmental categories which are growing rapidly.

It is either a question of accepting this fee schedule, which is infinitely better than anything that is in vogue in any of these categories, or turning it down and still having your categories, whether you like them or not, and taking the inadequate, paltry fees that are given.

It is a question of raising to a decent level the fees for these groups that are going to exist. We have no control over the setting up and the establishment of government categories. It is not just an indigent category. It is any category that is paid for by some governmental agency.

It has nothing to do with our private practice. It has nothing to do with anything in our private way of doing business. It is for the groups that we must treat, whose economic determination is made by somebody else, and who are with us whether we like it or not. So it is a question of getting a more adequate fee for those people for whom the government is going to pay the bill, or say we will throw down the schedule of fees and will accept what these governmental people will give us, which is always below cost.

That explains, I believe, the attitude of The Council in trying to arrive at something more equitable for these established groups which we are bound to have.

GEORGE WATERS, M.D. (St. Clair): I was very much interested in this discussion, pro and con. I as a delegate feel that I am in a position where I hardly know what to do when this resolution comes to a vote. I don't know whether I can go back and sell this to my county and to my Welfare Board. I fancy there are many delegates just in the same position that I am.


If this resolution is passed and many of us cannot put it across in our own counties, just where are we placed?

It would seem to me that there could have been an expression of opinion from the different county societies, so we have some idea of where we stand on this proposition, and we would arrive at a more definite conclusion in the whole matter.

I wonder what position we as delegates are in when we go back to our own county.

R. H. PRIN, M.D. (Wayne): In answer in part to the problem that this gentleman raises, one thing they can do, if the Welfare Board in the county will not pay an adequate fee, is to

(Continued on Page 1244)



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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

(Continued from Page 1242)

say, "Well, then, I just can't take care of the patient. That is all."

I want to bring another aspect of this proposal to your attention. We have a very positive example of this in the field that has to do with the care of the blind and the partially blind. Those people who get in government positions, where they can say to you as a doctor, "We want you to do this," can also say to you, "Here is a report we would like to have you fill out," in order that someone may be able to take all this data—put it together and write an article or something of that kind.

That is the status of the situation right now as far as the ophthalmologists are concerned. Out from that bureau that has to do with the care of the blind, they send a long blank to be filled out. Why, it is worth what they pay to fill that out alone, for it is in such detail. The detail of an ophthalmological examination would take so much time and there is so much that is unnecessary. They pay \$5 for an examination, that we wouldn't think of doing for less than \$10, and it ought to be \$15 or \$20, in our private practice, because it is so much more extensive than necessary.

What can we do about it? Some of us have said we will have to stop making those examinations, and yet we don't want to place ourselves in the position of saying we will not co-operate with a problem that has to do with the blind.

This thing came to the Detroit Ophthalmological Club, to which belongs practically every ophthalmologist of Michigan. We went over it, as it came to us, and set this schedule that we thought was all right and with which we will go along.

Gentlemen, it is the only backing we have—in answer to these agencies, who want us to make out this great schedule which is wholly unnecessary. We can say to them, "Now, the members of the Michigan State Medical Society are for this schedule. We will not do this for less. We may do it for more. We will not do it for less."

H. A. LUCE, M.D. (Wayne): I am stating this only as an opinion. It is my honest opinion that if we adopt this schedule and unite in putting it over, we have the only answer at the present time to the Murray-Wagner-Dingell Bills.

This gentleman in the back of the hall wanted to know what he should do if he didn't adopt this. He can go under the Murray-Wagner-Dingell Bills. He will have to.

S. L. LOUPEE, M.D. (Cass): After listening to all this discussion, I have tried to boil down a few facts in my own mind and a few questions.

The important thing is, not how many dollars you are going to get into your pocket and mine. The important thing is, How is this going to affect organized medicine? How better than through this approach can we answer the governmental agencies which are pushing themselves upon us?

I am not sure that it will make any particular difference. I can see that an organized front will add to our strength in resisting it.

I also think that in this announcement which we had from the doctor in Dickinson County, I see a grave possibility of something creeping in that we have not yet thought of. The doctor states that the fee they get from the governmental agencies is high. He also says in his private practice he can adjust the fees to the individual case—all very good. Now what does this amount to? It amounts to the fact that before long the medical profession, as individuals, will be willing to deal with governmental agencies because these agencies pay better fees, and that will be inviting state medicine because we are better paid.

Don't think for a minute that the Federal Government cares a rap about the fees we get. They will pay twice as much as quickly as they will pay what they are paying for the price of commanding the loyalty of organized medicine in Michigan and throughout the United States. We have seen that very same thing developed in the Children's Bureau.

At first their fees were comparably low. Gradually they were raised, and they were brought up to the point where they were attractive to young men. They couldn't turn them down. They had to make a living, and they dealt with the government and made out all of these rigmarole reports for the purpose of getting the fee. They co-operate.

Here is the same approach to the same question, and before we know it, we will be drifting into a channel that will lead directly into state medicine. So much for that.

I have one more thought. How are you going to enforce it? If there is a body representing the doctors of the state of Michigan that can decide how to enforce it, it is this body. You men, myself included, represent your counties and represent the agencies in your counties through which this can be enforced. Can you as an individual go back and sell it to your practitioners? Can you bring into line the agencies that you have to deal with?

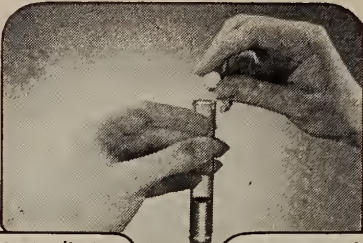
I am not sure whether you can or not, but I think it would be well right here to take a rising vote from this organization to see whether we think it is possible to enforce this plan.

Those things have come to my mind. I have passed them on to you.


THE SPEAKER: May I say a word? We are going to have to adjourn very shortly. I hope, if you are ready for a vote we will have it at this meeting. If not, we will have to continue the discussion tonight.

F. J. O'DONNELL, M.D. (Alpena): I am a lone delegate from a small county, a general practitioner, and I was in on our local county when we arrived at these fee schedules. We buried a doctor that afternoon. The meeting was called hurriedly. About five of us showed up for the meeting, and before the meeting was over, after fifteen or twenty minutes, there were two of us left. Some had to go to dinner. Some had to go here and

(Continued on Page 1246)



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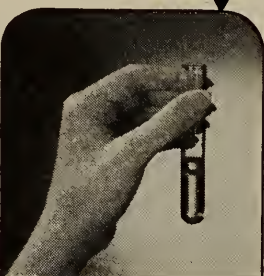
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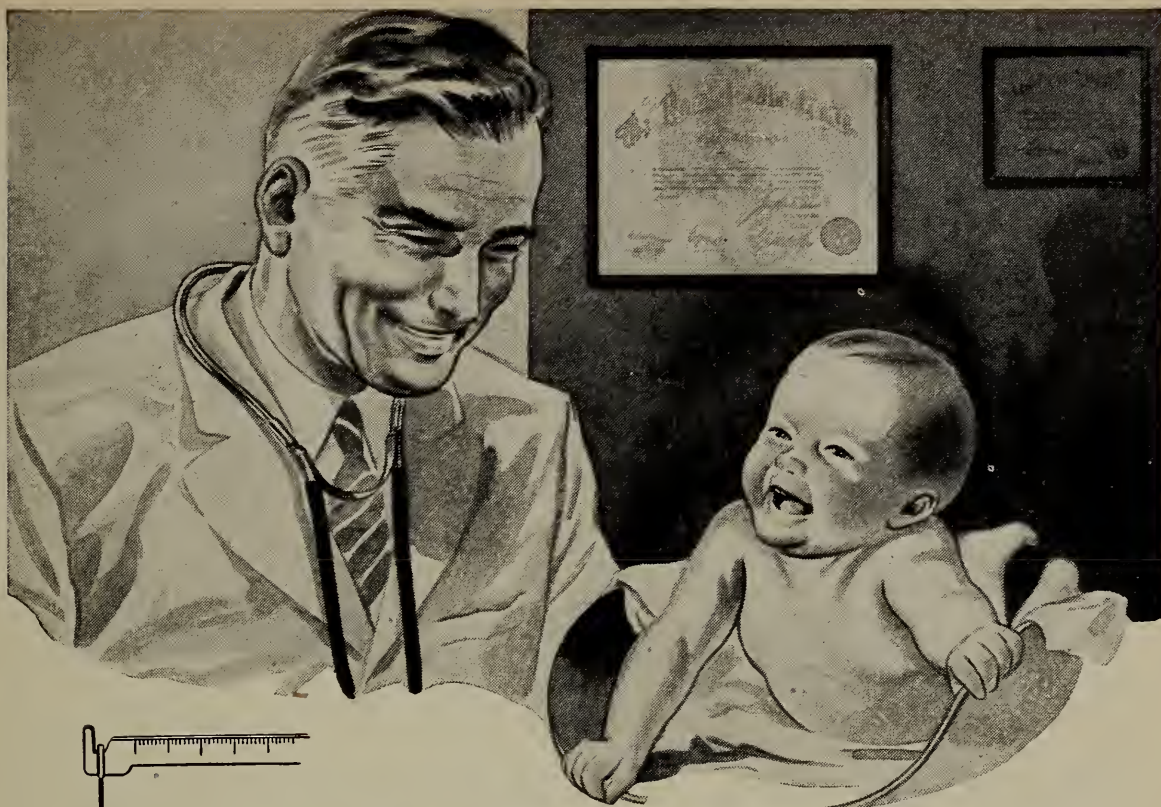
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(Continued from Page 1244)

what not. They said, "Whatever you two fellows do is all right with us."

They sent me down here as a lone delegate, and led me into a fee schedule like that, to use my own judgment. I believe I would have the responsibility of that group of voting the way I deem best.

I don't think in a lot of the smaller counties the medical men are capable of arriving at or making a disposition of this.

I want to state one particular instance of a man in our county who had a fractured femur in a child, which happened to be a Crippled Children's case. He paid his assistant \$10 and paid the anesthetist \$10, and when the fee came back from the Crippled Children's Bureau, it was a total of \$25 for taking care of the patient for sixty or ninety days, because Alpena was operating under a fee schedule made out in 1924. He didn't know a thing about it.

So I don't believe the doctors in the smaller communities will take the time to do it. I would rather trust my lot to a man like Dr. Novy and his Committee to solve this situation for us.

S. W. INSLEY, M.D. (Wayne): The big weakness, as I see it, in the position taken by Dr. Novy is to the general effect that they have not set up any means by which they could implement this idea. There is no machinery.

It would be my idea that we might adjourn and hold this thing over until this evening, and give some further thought to the implementation.

THE SPEAKER: Before we adjourn, there are one or two other things we have to do.

R. L. NOVY, M.D. (Wayne): Dr. Insley has asked why we haven't set up exact details of how it should be done. The Committee was formed to establish a fee schedule. It was not formed to decide on how we should do it, because we did not know what your action would be, and it wasn't within the jurisdiction of the Committee.

You have heard Dr. Christian speak. You have heard the doctor from Dickinson County on how things were done. It can be done if you stand back of it.

THE SPEAKER: Would you like to think it over and vote on it tonight?

SEVERAL VOICES: Yes.

G. H. WOOD, M.D. (Northern Michigan): There is one thing I must say before this discussion closes. I have a duty to perform. My society is the Northern Michigan Medical Society. We took the question up at the last meeting and discussed it and voted unanimously to approve the fee schedule, and they sent me down here to vote for it.

T. K. GRUBER, M.D. (Wayne): Mr. Chairman, I move that the subject be laid on the table. I believe that the men here do not know just what they want. I think they should have time to mull this over in their minds this afternoon.

SEVERAL VOICES: No.

THE SPEAKER: Is there a second to Dr. Gruber's motion?

R. H. DENHAM, M.D.: I second the motion.

THE SPEAKER: The motion is made by Dr. Gruber, seconded by Dr. Denham, that we lay this on the table. All in favor say "aye"; opposed. Will those who are in favor of the motion please rise? Will the "noes" please rise? The motion is lost.

Are you ready for the question on the main motion?

(Calls for the question.)

R. H. DENHAM, M.D. (Kent): I think we have got to consider this further. For instance, in Kent County, how can we implement this? In Kent County we have a salaried city physician and surgeon, a salaried county physician and surgeon, who do all this work practically for the city and for the county. We will never be able to do it in Kent County, as I see it, unless there is some manner planned for it.

THE SPEAKER: The question is asked for. All in favor of the motion, which was to adopt the report of the committee to adopt the resolution as amended by the committee say "aye"; opposed. Will the "ayes" please rise? Will the "noes" please rise? The motion is carried.

We will adjourn until eight o'clock.

(The meeting adjourned at one-fifteen o'clock P. M.)

(To be concluded in December issue)

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* * *

ANNUAL REPORT OF THE RETIRING PRESIDENT

Your president's report will be divided into two main parts. First, a report of her activities incident to office, and second, her conclusions and recommendations concerning the work of the auxiliary.

The activities incident to office consisted of: (1) attending the meetings of the national Conference of state presidents and committee chairmen in Chicago last November; the secretaries' conference of the Michigan State Medical Society in Detroit in January; (2) presiding at the post-convention board meeting last September; the mid-year meeting in November; this annual meeting; (3) compiling the report of Michigan's plans presented at the Conference in Chicago, and report of that meeting presented at our mid-year meeting; compiling Michigan's annual report for publication in the Bulletin; also this report; (4) Helping prepare the one issue of the *Auxiliary News* and writing various articles for the auxiliary page of THE JOURNAL.

May I add here, that two issues of the *News* were planned and finances available. With medical legislation of such paramount importance, the committee thought that the second issue of the *News* might well be published following the introduction of such bills in the state or national lawmaking bodies. These bills were not introduced until April and May. With the legislatures adjourning shortly and few auxiliaries meeting during the summer, it was felt that little would be accomplished by putting out a *News* at that time. We concluded that a preconvention number would be better. The last of July we were told that it would be impossible for the Auxiliary to hold a meeting this fall. Three days after V-J Day, I heard over the radio that some convention regulations had been relaxed. Hastily calling the Michigan State Medical Society and several Auxiliary members, it was decided to hold the annual meeting. It was now too late to publish another issue of the *News*. But more concerning this meeting; with the Michigan State Medical Society not having the usual convention, we realized that our attendance would be greatly reduced. Hence, the decision to cut down our

meetings, to have an annual meeting, not a convention. Board members were notified and county presidents requested to inform their delegates. My apologies to the membership as a whole, but time and expense would not allow notifying each member. It is my belief that personal contact is of inestimable value in planning the year's work; also that it is important to get this information to the counties (through their representatives) in time for it to be incorporated into their program. This influenced the decision to have this meeting and I accept the responsibility of so doing.

To get back to your president's activities: fifteen counties were visited including Houghton-Baraga-Keweenaw and Delta-Schoolcraft in the Upper Peninsula. In every instance the work done and enthusiasm shown was a real inspiration. To see each auxiliary carving for itself a niche in its own community, worthy of association with the medical profession, can only make us all proud to be Auxiliary members. The gracious hospitality shown your president all over the state could not be surpassed and was very wholeheartedly appreciated.

Recommendations based on this year's experience:

Each year seems to add new projects to the activities requested by the national and state organizations of each county auxiliary. In Michigan, which is seventh in size among the state auxiliaries, two-thirds of our counties have a membership of less than thirty. This cannot help but limit the activities that can be undertaken. Therefore, I would recommend that activities be listed in regard to importance so that the counties may be able to choose better that which they would do.

Since the influence of each auxiliary is directly related to its place in community activities, it seems that local projects should receive a top priority. Having acquired this influence it should be used to better the public relations of the medical profession and encourage only beneficial legislation in this field. Presentation of speakers, contacting legislators, helping to increase the radio audience of the programs presented by the American Medical Association and Michigan State Medical Society, and better distribution of *Hygeia* aid in this work.

Next, our interest should be directed toward Health Education, as evidenced by our Radio Speech Project, sponsorship of talks on nutrition, et cetera.

The war has ended, and with it many of our cares and worries have disappeared. But not all of our problems have vanished. "Reconversion" is now the key word and many new social adjustments are being made. It is no idle statement that there is "no going back; the world of tomorrow will be different from the world of yesterday." Let us help to make it a better world, and furthering the aims of medicine is one sure way of accomplishing this purpose.

In conclusion, I would like to thank, on behalf of the
(Continued on Page 1268)

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What's What

Louise F. Schnute, M.D., Grand Rapids, addressed the Ottawa County Medical Society on "Rheumatic Fever," at the Warm Friend Tavern in Holland, October 26.

* * *

Norman F. Miller, M.D., Ann Arbor, is the author of an original article "Tubal Patency Tests" which appeared in *JAMA* of September 22.

* * *

E. H. Watson, M.D., Ann Arbor, is the author of an original article "Boric Acid" which appeared in *JAMA* of September 29.

* * *

The International College of Surgeons will hold its 10th Annual Convocation in Washington, D. C., December 7-8, 1945.

* * *

The 1945 March of Dimes netted \$16,589,874.00 to the National Foundation for Infantile Paralysis, Inc. Michigan contributed \$673,515.85.

* * *

Nathan Hack, Detroit, founder of the Hack Shoe Company, was honored on October 17 at a testimonial dinner given by the Michigan Retail Shoe Dealers As-

sociation on the completion of eight years' work as editor of *The Journal* of the Association.

* * *

The Annual Conference of State Secretaries and Editors, sponsored by the American Medical Association, will be held in February, 1946.

* * *

C. L. Hess, M.D., Bay City, has been appointed as MSMS representative to the State Advisory Committee on Physical Rehabilitation, the federal state project in the State Dept. of Vocational Education.

* * *

The AMA Constructive Program for Medical Care, sponsored by its Board of Trustees and Council on Medical Service and Public Relations, was endorsed by the MSMS House of Delegates at its 1945 session.

* * *

"The Doctors Talk It Over" is the title of a new national radio program sponsored by Lederle Laboratories which began October 16, 1945. The first coast-to-coast broadcast over the ABC Network discussed the subject of "Streptomycin."

(Continued on Page 1252)

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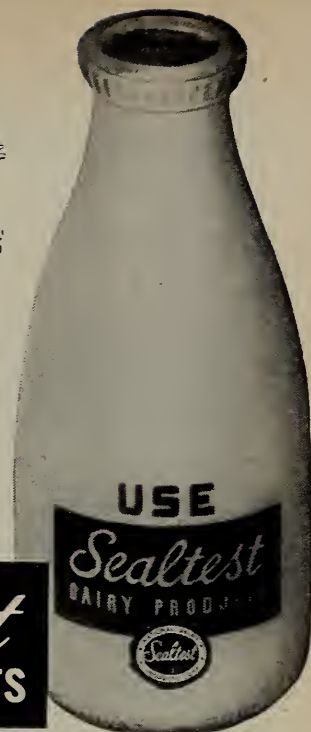
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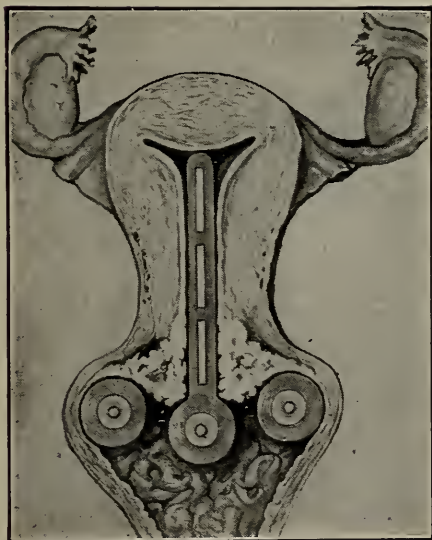
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(Continued from Page 1250)

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R. S. Morrish, M.D., Flint, President of the Michigan State Medical Society, addressed the Michigan Association of Welfare Boards and Boards of Supervisors at its Lansing meeting on October 10. Dr. Morrish's subject was "Co-operation by All for Better Health."

* * *

The MSMS Committee on Rural Medical Service, appointed at the suggestion of the AMA Committee on R.M.S., is composed of H. B. Zemmer, M.D., Lapeer, Chairman; R. J. Hubbell, M.D., Kalamazoo; and E. R. Witwer, M.D., Detroit.

* * *

State Society dues for 1946 will remain at \$12.00. The assessment for 1946, levied by the 1945 House of Delegates for public relations and information, will be \$25.00. The total payable to the Michigan State Medical Society in 1946 will be \$37.00 per capita.

* * *

MSMS Commercial Radio Program, Radio Station WJR, every Friday at 6:30 p.m., E.S.T.

This is part of the public relations program of your State Medical Society. Urge your patients to listen in. Public relations begin at home.

* * *

GI Bill of Rights. A digest of the benefits for medical veterans under the GI Bill is contained in an explanatory bulletin published by the AMA Bureau of Information. Copies are available by writing the Bureau, at 535 N. Dearborn Street, Chicago 10, Illinois.

* * *

Henry L. Smith, M.D., Detroit, was elected President of Mt. Carmel Mercy Hospital staff on September 12. William A. Chipman, M.D., was chosen Vice President; Eugene W. Secord, M.D., Secretary.

The Annual Clinic Day of the Hospital will be held on January 30, 1946.

* * *

The 36th General Hospital, composed of Doctors of Medicine associated with Wayne University College of Medicine, has been cited by Major General Paul R. Hawley, USA Chief Surgeon for "High quality of the medical personnel . . . and outstanding service to our Country."

* * *

In the Bill of Rights, the tenth amendment to the Constitution of the United States holds:

"The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, nor reserved to the states, respectively, or to the people."

Does the Super EMIC-Pepper Bill invade the sacred Bill of Rights?

* * *

Paid advertising in newspapers. The Berrien County Medical Society is sponsoring paid advertisements in the News-Palladium of Benton Harbor, Michigan. The first

(Continued on Page 1254)

 CAT	 COTTON SEED	 SILK FLOSS	 ORRIS ROOT	 MEAT	 GOAT	 BANANA	 FLAXSEED	 SOY BEAN	 CORN MEAL	 COW	
 GREEN PEAS	<p><i>Whether YOUR PATIENT IS Allergic TO</i></p> <h1>INHALANTS INGESTANTS CONTACTANTS</h1> <p>THE MOST SATISFACTORY METHOD of treatment is by hypodermic desensitization, and among the most satisfactory desensitizers are Hollister-Stier Allergens, both stock and autogenous. Hollister-Stier also provides carefully selected sets for ready identification of the specific excitant. • Just released for professional request is a new comprehensive folder on Dust Allergy, and Outlines on food, protein and pollen allergens. Our personalized Allergy Service is also available for interpretation of findings. • All Hollister-Stier literature contains easy-to-follow directions on collecting of samples, testing, patient instruction, and treatment. All Hollister-Stier Allergens are <i>specific • effective • stable</i></p> <p style="text-align: right;">M-6</p>									 FURS	
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(Continued from Page 1252)

quarter page spread appeared in the issue of October 16 and was titled: "Doctor Rationing! Do You Want It in America?"

* * *

Mt. Carmel Mercy Hospital, Detroit, has printed the following placards and distributed them to all staff members who have agreed to place them in their office waiting rooms, as notice to the public:

"If you have been a patient here because your doctor has been in the armed forces, we suggest you contact him upon his return."

* * *

Jerome Conn, M.D., of Ann Arbor, has been reappointed to the Michigan Nutrition Committee, to represent the Michigan State Medical Society.

Dr. Conn has given several years' work to the Nutrition Committee. The Council of the Michigan State Medical Society placed on its minutes a vote of thanks to Dr. Conn for his efforts in connection with the work of the Michigan Nutrition Committee.

* * *

"*The Health Dollar*" is the title of a brochure published by Household Finance Corporation in its "Money Management" series. This booklet contains many helpful hints for laymen seeking information on obtaining medical service. Copies for distribution to patients may be obtained by writing Household Finance Corporation, 919 N. Michigan Ave., Chicago, Ill.

* * *

Data on Military Members. Medical men in military service are returning, a few every month. The State Medical Society desires to place these military members on the *active* rolls, immediately upon their return, and would appreciate notification by MSMS members concerning the return and new addresses of returning medical veterans. Write 2020 Olds Tower, Lansing 8, Michigan.

* * *

The Eighth District Meeting was held at the Park Hotel, St. Louis, Michigan, on Thursday, October 4, under the Chairmanship of Councilor W. E. Barstow, M.D. Speakers included President R. S. Morrish, Flint, Councilor F. H. Drummond, M.D., and Secretary L. Fernald Foster, M.D., of Bay City and Executive Secretary Wm. J. Burns, Lansing. Forty-eight were present, representing the counties of Saginaw, Midland, Gratiot-Isabella-Clare and Tuscola.

* * *

Col. Harrison S. Collisi, Grand Rapids, has been awarded the Bronze Star Medal with Oak Leaf Cluster "for meritorious service in connection with military operations—and for his superior organizational ability, untiring efforts and keen foresight in planning, organizing and operating a general hospital which displayed a high degree of perfection and reflects high credit upon himself and the armed forces of the United States."

(Continued on Page 1256)

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(Continued from Page 1254)

A. S. Brunk, M.D., Chairman of Presidents for Twenty-five State Medical Societies, has called a Conference of Presidents, Presidents-elect, Secretaries and Executive Secretaries of State Medical Societies, pursuant to instructions given him at both the Detroit and Denver Public Relations Conferences. The session will be held at Hotel Continental (formerly the Medinah Club), Chicago, on Sunday, December 2, 1945.

Dr. Brunk addressed the general session of the Kentucky State Medical Association in Lexington on October 28. His subject was "Voluntary Pre-pay Medical Care Plan."

* * *

L. Fernald Foster, M.D., Bay City, Secretary of the Michigan State Medical Society, addressed the Rotary Club of Battle Creek on October 22. His subject was "Better Health for the American People." On October 8 he spoke to the Bay City Audit Education Conference on "Health Proposals Before Congress." Dr. Foster also was guest speaker at the dinner meeting of the House of Delegates, Medical Society of the State of Wisconsin, Milwaukee, on Saturday, October 20. Dr. Foster spoke on "Voluntary Group Medical Care Programs."

Dr. Foster has been appointed as the Michigan State Medical Society representative on the Advisory Committee to the State Department of Public Instruction, Health, Physical Education and Recreation Project, including School Camping and Outdoor Education.

* * *

The Calhoun County Medical Society is working on a definite program of postgraduate education for returning medical veterans and for resident hospital interns. Three projects are being studied: (a) to train interns and residents locally; or (b) to co-operate with the University of Michigan Hospital on exchange residencies; or (c) a two-year general practice internship, rotating interns to the smaller surrounding hospitals. The program is being developed in co-operation with the Kellogg Foundation.

* * *

The Jackson County Medical Society is placing advertisements in the Jackson Citizen-Patriot announcing the return to active practice of medical veterans. Each announcement includes a biographical sketch of the medical man's military service, information on his new professional address, his telephone number and his office hours.

This plan of aiding returned medical veterans to re-establish their practices was conceived by the Ethics Committee of the Jackson County Medical Society.

* * *

The 17th General Hospital, composed of Doctors of Medicine from Harper Hospital, Detroit, was recently honored by awards to eight of its personnel. Colonel Henry R. Carstens, Detroit, was given the Legion of Merit, Lt. Col. Coral Bremer, Detroit, Bronze Star; Lt. Col. Clair Douglas, Detroit, Bronze Star; Lt. Col. Leslie F. Wilcox, Detroit, Bronze Star; Major Herbert W. Har-

(Continued on Page 1258)

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Quality carries on



(Continued from Page 1256)

ris, Lansing, Bronze Star; Major Thomas N. Horan, Detroit, Bronze Star; Major Alvin E. Price, Detroit, Bronze Star, and T/3 Harold Barrett, Detroit, Bronze Star.

* * *

The Wayne County Medical Society has circularized its membership with the following questions in order to obtain vital information to assist returning medical veterans:

- (1) Can you share your office with a medical veteran?
- (2) Will you be able to utilize a medical veteran as an assistant? Associate? Partner?
- (3) Can you use a medical veteran to make calls for you?
- (4) Is there any office space suitable for a physician for rent in your building or neighborhood?

* * *

"Political Medicine and Freedom of Enterprise" is the subject of a concise analysis of the provisions of the Wagner-Murray-Dingell Bill, published by the National Physicians Committee, Pittsfield Bldg., Chicago 2, Illinois.

The revolutionary nature of the compulsory health insurance provisions of this proposed legislation in Congress are outlined in this excellent brochure.

Copies may be obtained by writing John M. Pratt, Administrator, National Physicians' Committee, Pittsfield Bldg., Chicago 2, Illinois.

The MSMS Commission on American Health Care, appointed upon instruction of the 1945 MSMS House of Delegates as a result of the Pino Resolution, is composed of R. H. Pino, M.D., Detroit, Chairman; H. A. Kemp, M.D., Detroit, representing Wayne University College of Medicine; H. M. Pollard, M.D., Ann Arbor, representing University of Michigan Medical School; B. R. Corbus, M.D., Grand Rapids; and Fred H. Drummond, M.D., Kawkawlin. This Commission will study the subject of American health care and report its findings to the 1946 MSMS House of Delegates.

* * *

The Lapeer County Medical Society was host to the dental and legal professions of Lapeer County on October 5. The meeting at the Barrett Hotel in Lapeer was presided over by H. B. Zemmer, M.D., President of the County Society.

R. S. Moorish, M.D., Flint, President of the Michigan State Medical Society spoke on "Progressive Activities of the Michigan State Medical Society."

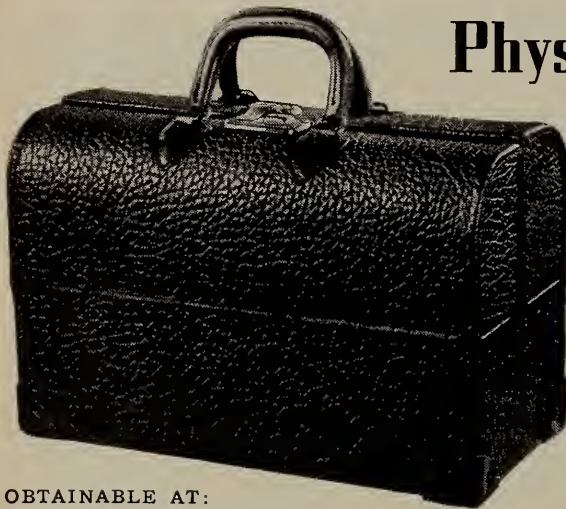
Wm. J. Burns, Lansing, Executive Secretary of the State Society, spoke on "Better Health for the American People."

Among the guests were Past President H. E. Randall, M.D., of Flint, Judge G. W. Desjardins and Judge Glenn Hollenbeck of Lapeer County.

* * *

Watson B. Miller has been appointed Federal Security Administrator by President Truman, to succeed Paul V.

(Continued on Page 1260)



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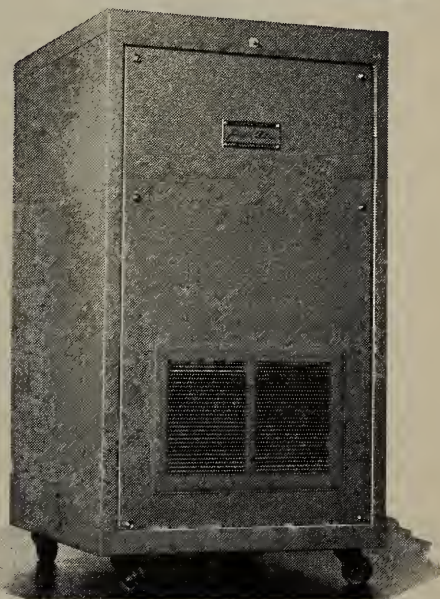
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(Continued from Page 1258)

McNutt, now High Commissioner to the Philippines. Mr. Miller had spent four years as Assistant Federal Security Administrator. The United States Public Health Service, Food and Drug Administration, Social Security Board, and Procurement & Assignment Service are now under Mr. Miller. If President Truman's reorganization program is effected, the Children's Bureau may be transferred to the United States Public Health Service under Mr. Miller.

The many friends of Mr. Miller in the medical profession are gratified at his selection as Federal Security Administrator.

Meritorious Service Unit Plaque Award

As published in General Orders No. 195 19th July, 1945, announcement is made of the award of the Meritorious Service Unit Plaque to the 17th General Hospital, for superior performance of duty in the accomplishment of exceptionally difficult tasks in the Peninsular Base Section for the period 11 June 1944 to 1 December 1944.

Fiftieth Anniversary of Roentgen's Discovery

November 8, 1945, a memorial dinner was held in the Palmer House in Chicago in honor of the discovery

of the x-rays fifty years ago by Wilhelm Conrad Roentgen. The American College of Radiology calls attention to this anniversary and the great benefit to humanity that has followed this discovery.

The Chicago Medical Society, the Chicago Roentgen Society, the Institute of Medicine of Chicago and the Chicago Physics Club acted as co-sponsors and hosts for the memorial dinner.

The dinner was one of the highlights of the national celebration of the 50th anniversary of Roentgen's discovery, the period of November 5 to 10 having been designated "X-Ray in Health Week" by the American College of Radiology.

Decorations of Michigan Doctors in the Armed Forces

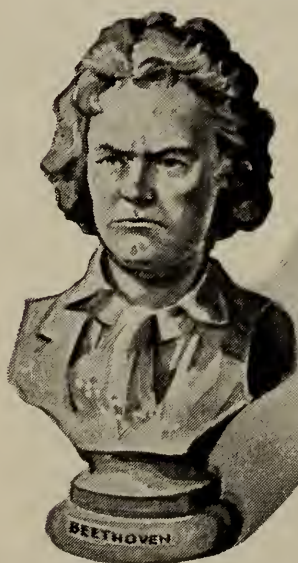
The Crown of Italy, from Crown Prince Umberto at the Quirinal, Sunday, June 3, 1945, was presented to Col. Henry R. Carstens of the 17th General Hospital.

The Bronze Star was presented on August 15, 1945, to: Col. Ashley, Lt. Col. McLester, and Captain Gladys Krusig.

Captain Regis F. Asselin of Detroit was awarded the Bronze Star "for distinguished and meritorious service, over and beyond the call of duty, in accomplishing malarial control in a highly malarial area."

(Continued on Page 1262)

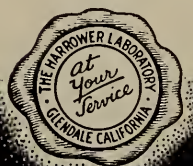
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(Continued from Page 1260)



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The Eye Bank for Sight Restoration

Recently an Eye Bank has been organized on the basis of the Blood Banks which have been so helpful in the past few years. A Council of seventy-five science, finance and business leaders has been named. Offices, 210 East 64th street, New York City. The Council will aid in the plan to establish a nationwide eye bank for obtaining and making available healthy corneal tissue to restore the vision of persons whose sight has been lost through affections of the cornea. The plan will include research, study and instruction of ophthalmologists in the delicate surgery required in the corneal graft operation.

It is estimated that five to seven per cent of all the 250,000 blind persons in the United States have lost their sight through opaque corneas. Thus the sight of perhaps 10,000 persons could be restored. The purpose of the Eye Bank is to locate, obtain and have access to the all-important corneal tissue wherever and whenever needed. The "capital stock" may be obtained only from persons whose sight requires the removal of an eye whose corneal tissue is unimpaired, or by obtaining the healthy eyes of persons immediately after death.

It is possible to preserve corneal tissue for utilization in the graft operation only seventy-two hours, therefore, it is necessary to arrange for the speedy collection and preservation of eyes immediately upon removal, and prompt use.

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In Memoriam

Thomas B. Cooley, Detroit, was born in Ann Arbor in 1871 and was graduated from the University of Michigan Medical School in 1895. He studied later at Harvard University and in Germany. He was chief of staff of Children's Hospital, Detroit, from 1921 to 1941, when he retired. Doctor Cooley was Detroit's first school medical inspector and organized a number of children's clinics. For his work, while he was in charge of Red Cross activities in Paris, in 1918-1919, which included caring for refugee children, he was decorated with the Cross of the Legion of Honor by the French Government. He was a former president of the American Academy of Pediatrics and author of many articles on anemias of children and was professor emeritus of pediatrics in Wayne University, College of Medicine. Doctor Cooley was elected to Emeritus Membership in the Michigan State Medical Society in July. He died October 13, 1945.

Frank D. German, of Pontiac, was born in West Bloomfield Township, March 17, 1880, and was graduated from the Detroit College of Medicine in 1906. He was first lieutenant in the Medical Corps in World War I and served as an examining doctor for the draft boards during World War II. Doctor German was health officer in Southfield Township for a number of years. He died September 26, 1945, after a two-year illness.

R. E. D. Hawley, of St. Clair Shores, was born in Marne in 1875 and was graduated from the University of Michigan Medical School. He completed his medical training at Harvard University, and for eighteen years practiced in Boston before returning to Michigan. Doctor Hawley was notable for his interest in all civic affairs and his philanthropic association with charitable projects. During the war years, Doctor Hawley was responsible for the training in first aid of hundreds of persons in St. Clair Shores, under auspices of the Red Cross and Civilian Defense Organizations. In practice he specialized in eye, ear, nose and throat. Doctor Hawley died September 21, 1945.

Morrell M. Jones, of Drayton Plains, was born April 14, 1891, in Imlay City and was graduated from Wayne University College of Medicine in 1915. He served with the medical corps in France in World War I. Doctor Jones had practiced in Drayton Plains for the last seventeen years. He was identified with many sports events in Pontiac and Drayton Plains, both as a physician and as a sponsor of young athletes. Doctor Jones died after a six months' illness, September 28, 1945.

Rowland F. Webb, of Grand Rapids, was born in Granton, Ontario, in 1875, and was graduated from the University of Toronto Medical School in 1897. He interned at the Blodgett Memorial Hospital for one year and at Butterworth Hospital for two years. He prac-

(Continued on Page 1268)



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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

TEXTBOOK OF NEUROPATHOLOGY. By Arthur Weil, M.D., Associate Professor of Neuropathology, Northwestern University Medical School. Second Edition, Revised and Enlarged. New York: Grune and Stratton, 1945. Price, \$5.50.

Growing knowledge of neurology has prompted the study of neuropathology, in addition to neuroanatomy. This text reflects the author's personal endeavor to study the subject from every possible standpoint, including chemical and physical data. Study of the living nerve cell is essential, but difficult on account of the chemical and other changes taking place within minutes after removal of the cells from the living organism. This is a textbook of pathology related to this special field. It is profusely illustrated showing nerve cells and tissues under varying pathological conditions. Diseases of the neuron, the glia, pathology of the myelin sheath and axis cylinders, arteriosclerosis, inflammation, infections, intoxications, injuries, degenerative disease, and tumors. Also a chapter on malformations. The book is well executed, and readable.

ESSENTIALS OF CLINICAL ALLERGY. By Samuel J. Taub, M.D., Professor of Medicine, Cook County Graduate School of Medicine. Attending Physician in Medicine, Cook County Hospital. Fellow of the American Academy of Allergy; Assistant Professor of Medicine, Rush Medical College of the

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University of Chicago. Baltimore: The Williams & Wilkins Company, 1945. Price \$3.00.

Fifty per cent of all people have at some time in their lives some manifestations of allergy. It is estimated that 20 per cent of the population have some type of hay fever, 40 per cent of whom eventually develop a bronchial asthma. That shows the importance of allergy studies to every doctor. This volume is written after twenty years of teaching experience to help the student and the general practitioner. Controversial subjects are avoided, accepted teachings are given. Diagnosis involves more than laboratory tests. Allergy is not a laboratory science, but a field of clinical medicine in which all diagnostic aids are to be used. Diagnosis and treatment are given special attention, and the treatment is detailed, giving the exact directions to be used where possible. The chapter on asthma is particularly interesting, including the liver influence. Dr. Taub has succeeded in producing a very instructive book.

DISEASES OF THE BREAST, Diagnosis, Pathology, Treatment. By Charles F. Geschickter, M.A., M.D., Lieut. Commander, Medical Corps, United States Naval Reserve, Director of the Francis P. Garvon Cancer Research Laboratory, Pathologist, St. Agnes Hospital, Baltimore; with a Special Section on Treatment in Collaboration with Murray M. Copeland, A.B., M.D., F.A.C.S., Instructor in Surgery, Johns Hopkins Medical School, Visiting Surgeon and Assistant Oncologist, University Hospital, University of Maryland Medical School, Visiting Oncologist, Baltimore City Hospitals. 593 Illustrations. Second Edition. Philadelphia: J. B. Lippincott Company, 1945.

This book is a masterpiece. The treatment of diseases of the breast is full, approaching the subject from every angle. The illustrations are profuse and well chosen. Chapters discuss the normal development and func-

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tion, breast changes in puberty, endocrine influence. Much attention is given to examination and diagnosis. The various hypertrophies are discussed and the effect of estrogens shown. The effects of pregnancy and lactation are shown. Acute diseases, benign and malignant tumors, occupy most of the volume. Much attention is given to differential diagnosis and treatment. Surgical procedures are well illustrated and minutely described. Experimental production of benign and cancerous tumors has been rewritten from the first edition, and devotes special attention to the hormones. The volume is most instructive and well printed in good easily readable type.

ANNUAL REPORT

(Continued from Page 1248)

Auxiliary, Dr. Harold W. Wiley, chairman of the Advisory Committee, Dr. L. Fernald Foster, Secretary of the Michigan State Medical Society, and Mr. William Burns, Executive Secretary of the Society, for the time they have devoted to the consideration of our problems and the excellent advice given. I also wish to express my appreciation to my able secretary, Mrs. C. F. DeVries, who does so much so easily it amazes me, and to each member of the Auxiliary, no one having refused any requested task.

To Mrs. Harvie, I pledge my continued support, and, I am confident, that with your support, the Auxiliary will go on to greater accomplishments.

Respectfully submitted,

(MRS. H. L.) LELA FRENCH, *President*

IN MEMORIAM

(Continued from Page 1264)

ticed in Grand Rapids all his professional life. He was a senior surgeon on the Butterworth Hospital staff from 1930 to 1934 and served as chief of staff. Doctor Webb was a member of the American College of Surgeons, and the New York Central Railroad Surgeons' Association. He was district surgeon for the Pere Marquette Railroad and served a number of industrial concerns of Grand Rapids. Doctor Webb died September 23, 1945, after a short illness.

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NOTE: Information, containers, tubes, etc., on request.

MEDICAL ADVICE BY RADIO*(Continued from Page 1124)*

the station contrary to the provisions of section 29 of the Radio Act of 1927 (47 USCA Sec. 109). This contention is without merit. There has been no attempt on the part of the commission to subject any part of appellant's broadcasting matter to scrutiny prior to its release. In considering the question whether the public interest, convenience, or necessity will be served by a renewal of appellant's license, the commission has merely exercised its undoubted right to take note of appellant's past conduct, which is not censorship. * * * We are therefore constrained, upon a careful review of the record, to affirm the decision."

**K F K B Broadcasting Ass'n v. Fed. Radio
Commission 47 F. (2nd) 670**

Although no further cases of practice of medicine by radio have come before courts of appeal, it is noteworthy that the Supreme Judicial Court of Massachusetts had occasion seven years after the Brinkley Case to pass on the question of giving legal advice by radio. It was held in the case of Rosenthal v. Shepard Broadcasting Service, Inc., 12 N. E. (2nd) 819, that in broadcasting a program consisting of statements of legal questions which members of the public were invited to submit, and of answers thereto, a broadcasting station violated the statute forbidding a corporation to practice law.

MEDICAL READJUSTMENT*(Continued from Page 1219)*

in our September number, and Amy Porter's article, "Babies For Free," *Collier's*, August 4, 1945 on maternity services for all mothers by the Children's Bureau.) Do you see anything explaining to the reader the background of the doctor of medicine and his life work?

We Need Better Public Relations

We must acquaint the world of the dangers to medical science and efficiency contained in certain proposals to form a great bureaucracy for the purpose of running the practice of medicine, and controlling the distribution of medical care. We must sell ourselves to the public as a desirable class of people if we are to survive as a desirable class of people.

For these and other reasons the House of Delegates authorized the prompt employment of a Public Relations Officer, one with experience and vision.

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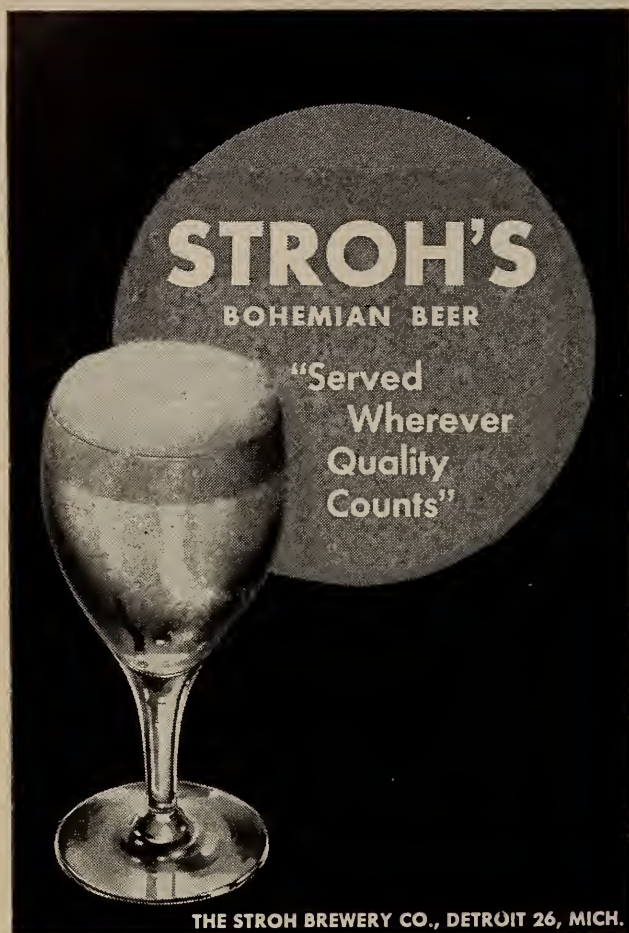
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Communication

At Sea, En Route to the States
20 September, 1945

Wilfrid Haughey, M.D., Editor
Journal Michigan State Medical Society
Dear Doctor :

I am enclosing a program of a medical society meeting I attended which I think might be of interest to you. In spite of the fact that a typhoon was just subsiding, the meeting was well attended, some seventy-five physicians being present. Had all of the Medical Corps connected with the Third Fleet been able to get ashore (because of the typhoon), the attendance would have been doubled.

Since the surrender, or in fact the day before, we have been busy with the repatriates. Clinically, they were most interesting. That work is now over, and we are taking the worst ones back to the states.

There probably were others from Michigan at the meeting, but I didn't happen to run into them.

Yours truly,
WALTER K. SLACK (MC) U.S.N.R. Commander
U.S.S. Rescue A.H. 18

* * *

FIRST UNITED STATES NAVAL MEDICAL MEETING IN JAPAN

18 September 1945—1500

YOKOSUKA NAVAL BASE OFFICERS' CLUB

Program

COMMODORE J. T. BOONE (MC) USN, Fleet Medical Officer, Third Fleet, *Presiding Officer*

BRIGADIER GENERAL G. W. RICE (MC) USA, Eighth Fleet Surgeon

"Medical Problems of Evacuation of Repatriates."

CAPTAIN H. H. CARROLL (MCO) USN, Senior Medical Officer USS Rescue

"Clinical Findings on Examination of Repatriates"

CAPTAIN F. L. McDANIEL (MC) USN, Senior Medical Officer USS Benevolence

"Care and Hospitalization of Serious Prisoner of War Cases"

COMMANDER G. H. McATEER (MC) USN, Senior Medical Officer Naval Operating Base, Yokasuka Naval Base:

"Relations Naval Shore Activities with Fleet."

NOTE: This meeting marks an historic occasion. It is the first medical meeting held by Naval, Medical, Dental and Hospital Corps Officers in Japan. American Medicine henceforth will materially influence, if not control, medicine in Japan. The American Occupation Forces, of which the Navy is a part, can through medical channels, further international medicine, with the world benefiting from joint medical investigations and practices. This meeting can well be regarded as the source from which will spring rich scientific advances.

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Alpena-Alcona-Presque Isle John W. Bunting, President.....Alpena E. S. Parmenter, Secretary.....Alpena	Macomb D. B. Wiley, President.....Utica C. A. Ruedisueli, Secretary.....Roseville
Barry Guy C. Keller, President.....Hastings J. K. Altland, Secretary.....Hastings	Manistee E. A. Oakes, President.....Manister C. L. Grant, Secretary.....Manister
Bay-Arenac-Iosco Thos. G. Wilson, President.....Bay City L. Fernald Foster, Secretary.....Bay City	Marquette-Alger George Keskey, President.....Marquette A. K. Bennett, Secretary.....Marquette
Berrien Frank K. Belsley, President.....Benton Harbor R. C. Conybeare, Secretary.....Benton Harbor	Mason R. C. Lintner, President.....Ludington W. S. Martin, Secretary.....Ludington
Branch N. J. Walton, President.....Quincy James Bailey, Secretary.....Coldwater	Mecosta-Osceola-Lake B. F. Franklin, President.....Remus John A. White, Secretary.....Big Rapids
Calhoun W. Leonard Howard, President.....Battle Creek Gilbert Patrick, Secretary.....Battle Creek	Medical Society of North Central Counties (Otsego-Montgomery-Crawford-Oscoda-Roscommon-Ogemaw-Gladwin-Kalkaska) Geo. A. Drescher, President.....Lewiston Stanley A. Stealy, Secretary.....Grayling
Cass C. M. Myers, President.....Dowagiac U. M. Adams, Secretary.....Marcellus	Menominee John T. Kaye, President.....Menominee Wm. S. Jones, Secretary.....Menominee
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*Deceased Dec. 25. 1944.

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MSMS PROGRAM OF PUBLIC RELATIONS AND INFORMATION

The 1945 MSMS House of Delegates adopted a resolution instructing The Council to inaugurate an augmented program of Public Relations and Public Information. To finance this vital project, the House of Delegates levied a per capita assessment of \$25.00 for the year 1946 on the membership.

This important resolution follows:

"WHEREAS, Some changes in the distribution of medical care, for the benefit of the people, have been affected by the Michigan medical profession through evolutionary methods; and

"WHEREAS, Improvement in medical service and in its distribution is the constant aid of the medical profession which will never cease its endeavors to bring good medical care to all the people; and

"WHEREAS, Not all the people of our State have been made aware of the salutary efforts of the Michigan medical profession, despite the work of public information performed by the Michigan State Medical Society especially during the past two years; and

"WHEREAS, One or more of the most progressive state medical societies have markedly increased their dues or levied special assessments to develop a fund sufficient to carry on an adequate program of medical public relations, therefore, be it

"RESOLVED, That a per capita assessment of twenty-five dollars (\$25.00) be levied for the year 1946 for purposes of public education and public relations."

MSMS Radio Hour, WJR, Detroit

SHOUT ABOUT THE BENEFITS OF VOLUNTARY MEDICAL SERVICE

One phase of the proposed Public Relations program embodies the employment of a full-time public relations counsel in the MSMS Executive Offices; leadership to county societies with their public relations activities of a local character; continued participation in the Michigan Health Council and its public relations projects; encouragement of more commercial medical radio and public relations programs in other parts of the country to lend leadership and stimulation to other state medical societies; stimulation in the development of a National Health Congress.

Michigan is fortunate in having an outstand-

ing profession of medical scientists. Its type of medical care is of high quality. Medical practice in this state is aided by the supplemental activity of its fiscal agent, Michigan Medical Service which now has a total of 868,498 subscribers. Added to this, our state is blessed with outstanding health legislation. These accomplishments are something to shout about, to tell to all the people so that they may appreciate the values of Michigan Medicine. With this in mind, the 1945 House of Delegates adopted the resolution to increase greatly the public relations work of the Michigan State Medical Society to the end that the people may know and be fully appreciative of the benefits of the voluntary type of medical care in contrast to the inadequacies of political, compulsory medicine.

MSMS Radio Hour, WJR, Detroit

RETURN TO COUNTY SOCIETIES OF \$5.00 ASSESSMENT OF 1945

The Executive Committee of The Council of the Michigan State Medical Society, at its November 8 session, voted to approve the report of its Committee on Medical Veterans' Readjustment Program which included a recommendation that the proceeds arising from the \$5.00 assessment of 1945 for the Medical Veterans' Readjustment Program be returned to component county societies in amounts proportionate to the sums paid by the individual members thereof.

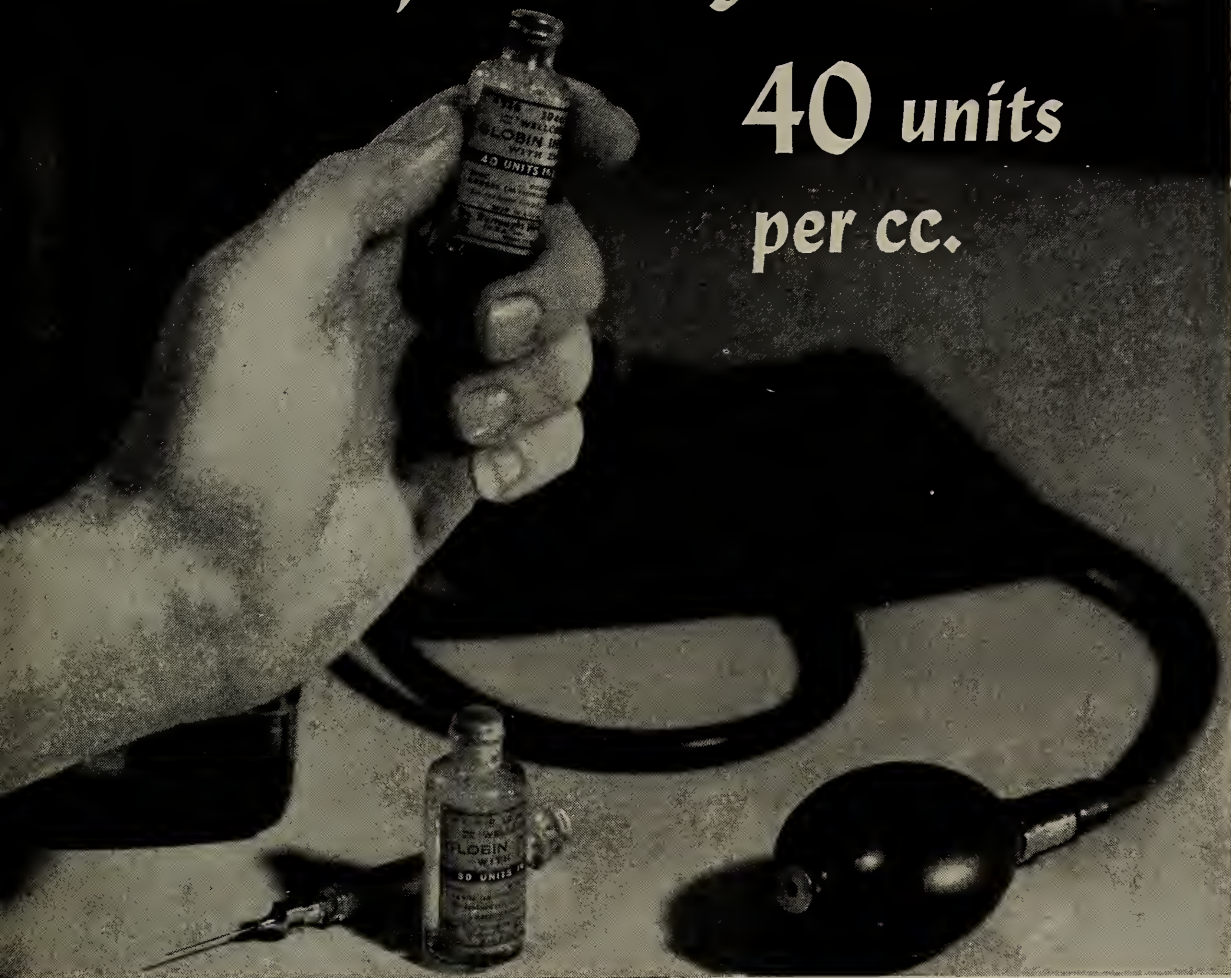
This action of transferring to the county societies approximately \$17,000 which has been held in trust by the State Society for the purposes of the 1944 House of Delegates' resolution—to aid returning medical veterans in their problems of post graduate education, relocation, and finances—is based on authority granted by the 1945 House of Delegates and on the further conclusion that this readjustment service is generally sought on the local level.

The Michigan State Medical Society will continue its committee on Medical Veterans' Readjustment Program; the work of this group in advising and helping returning medical veterans will be continued and augmented, to fill the need; but inasmuch as no additional personnel will be needed

(Continued on Page 1290)

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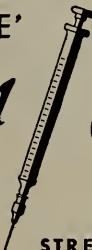


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ished activity at night minimizing the likelihood of nocturnal reactions.

The new 40 unit strength will be readily distinguishable by a distinctive *red* and tan label. As before, the 80 unit per cc. ampule is easily recognized by its *green* and tan label. Both strengths are available in vials of 10 cc. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. Literature on request. 'Wellcome' Trademark Registered.

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RETURN TO COUNTY SOCIETIES OF \$5.00 ASSESSMENTS OF 1945

(Continued from Page 1288)

ed to carry on this task, no extra funds will be required.

The monies forwarded to the county medical societies will aid these component groups to continue and to increase their efforts in behalf of doctors of medicine who return to Michigan upon separation from military service and who seek assistance from their county society.

All county medical societies have been urged by the House of Delegates to create "Postwar Planning Committees" with the responsibility of aiding all discharged veteran doctors of medicine and to co-operate with the State Society in assembling data of value to the medical veterans of Michigan.

MSMS Radio Hour, WJR, Detroit

MANY IMPORTANT RESOLUTIONS ADOPTED BY 1945 MSMS HOUSE OF DELEGATES

Thirty-seven resolutions were presented to the MSMS House of Delegates in September, 1945. The following digests indicate some of the more important resolutions:

1. **RESOLVED**, that the activities of the U. S. Children's Bureau be limited to education and research, and its powers be not increased to include control of the practice of medicine, in part or in whole.

2. **RESOLVED**, that the MSMS House of Delegates disapproves the Pepper Bill (S. 1318 of 1945) as drafted because it will fail to provide competent and adequate medical care for mothers, children, crippled children and others, and because the passage of this proposal in its present form would tend to pauperize patients who are financially independent, and to limit free choice of physicians.

3. **RESOLVED**, that the House of Delegates of the American Medical Association take whatever action is proper at this time to create as soon as possible a new Section of General Practice to be duly constituted of equal rank and authority with the other sections already established, and that the delegates from Michigan are hereby instructed to introduce this resolution into that body, and that copies of this resolution be mailed to all AMA Delegates, and to all county medical societies of the nation through their state medical societies.

4. **RESOLVED**, that the MSMS Council take immediate steps to contact all members of the Society who have not yet signed cards pledging non-co-operation with a system of political medicine, and that the vital necessity of such co-operation be explained to them.

5. **RESOLVED**, that the MSMS House of Delegates recognizes the need for a National Health Congress representative of the medical, dental, hospital, nursing and pharmaceutical professions, and that it approves the creation of such a legislative body.

MSMS Radio Hour, WJR, Detroit

UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES

The 1945 House of Delegates adopted the Uniform Fee Schedule for Governmental Agencies, developed by the Michigan State Medical Society which is "to be considered the minimum fees for the service named."

The Uniform Fee Schedule has been printed and mailed to all members of the Michigan State Medical Society and to all federal and state agencies having an interest therein.

County and district medical society secretaries have received additional copies of the schedule and also of the House of Delegates' resolution instructing them to "immediately notify the various governmental agencies with whom they are in contact that the Uniform Fee Schedule of the Michigan State Medical Society will henceforth be in force as the minimum fee schedule for the care of governmental wards and for indigents, so that the medical profession may not be penalized by being forced to perform services at a financial loss."

MSMS Radio Hour, WJR, Detroit

RHEUMATIC FEVER DIAGNOSTIC CENTERS

The Michigan State Medical Society's Committee on Rheumatic Fever Control is sponsoring Consultation and Diagnostic Centers in Ann Arbor, Bay City, Flint, Grand Rapids, Jackson, Kalamazoo, Lansing, Marquette and Traverse City.

The fundamental rules for these centers include

1. The work shall be limited to consultation and diagnostic service only.
2. All reports and recommendations shall go to a private doctor of medicine, on uniform blanks.
3. Indigents are the responsibility of the Michigan Crippled Children Commission. Private patients shall be charged a fee.
4. Reports shall be made of all cases to the Michigan Department of Health, on uniform blanks.
5. Uniform blanks shall be used by all Centers. Accurate records shall be kept, together with follow-up reports.

(Continued on Page 1292)

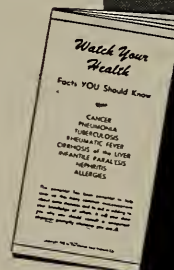
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Until research leads us to the solution, the public should continue to be educated — given the facts about polio so they will not become panicky during an epidemic, but will know how to employ the best preventive measures.

In the pamphlet "Watch Your Health" we have given such information on poliomyelitis—one of the seven serious diseases discussed. Copies for distribution to your patients are available on request.



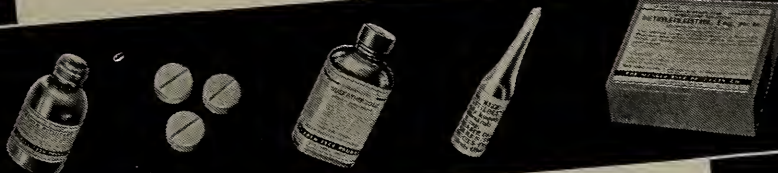
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RHEUMATIC FEVER DIAGNOSTIC CENTERS

(Continued from Page 1290)

6. Definite follow-ups shall be established, and be included among recommendations to the referring doctor of medicine.
7. Each Center shall be in a hospital approved by the Michigan Crippled Children Commission.

The local Rheumatic Fever Control Committees will send to all doctors of medicine in their areas a notice that they may refer their cases to the Consultation and Diagnostic Center on a particular day. No treatments shall be permitted in these Centers. This is not a free consultation service, except to indigents, in which case the Michigan Crippled Children Commission pays the fee. The physician-patient relationship shall be maintained.

The Center will give a helping hand to the family practitioner in that he may send a child to the Center to obtain laboratory tests not always available to the average doctor of medicine, to determine the child's condition.

Treatment services are to be given by the family practitioner. It is his responsibility to see that the treatment is carried out.

Personnel of Local Rheumatic Fever Control Committees

Ann Arbor—H. H. Riecker, M.D., Chairman; P. S. Barker, M.D., Mark Marshall, M.D., J. L. Wilson, M.D., T. H. McEachern, M.D., P. H. Bassow, M.D.

Bay City—L. Fernald Foster, M.D., Chairman; R. N. Sherman, M.D., W. G. Gamble, M.D., C. L. Hess, M.D., W. S. Stinson, M.D., H. L. Woodburne, M.D.

Flint—Lafon Jones, M.D., Chairman; M. S. Chambers, M.D., F. W. Baske, M.D., Robt. Jermstad, M.D., W. W. Stevenson, M.D.

Grand Rapids—H. C. Robinson, M.D., Chairman; Clarice L. McDougall, M.D., Louise Schnute, M.D.

Jackson—Frank Van Schoick, M.D., Chairman; Cecil Corley, M.D., G. R. Bullen, M.D., A. K. Payne, M.D.

Kalamazoo—H. S. Heersma, M.D., Chairman; L. W. Gerstner, M.D., John Littig, M.D., R. B. Fast, M.D., H. R. Prentice, M.D.

Lansing—H. L. French, M.D., Chairman; E. W. Brubaker, M.D., F. S. Cross, M.D., L. C. Towne, M.D., Milton Shaw, M.D.

Marquette—M. Cooperstock, M.D., Chairman.

Traverse City—Mark Osterlin, M.D., Chairman; B. B. Bushong, M.D., J. G. Zimmerman, M.D., R. T. Lossman, M.D.

MSMS Radio Hour, WJR, Detroit

CHICAGO CONFERENCE OF PRESIDENTS

Under the leadership of A. S. Brunk, M.D., Detroit, immediate Past President of the Michigan State Medical Society, the Presidents, Presidents-elect, Secretaries and Executive Secretaries of State Medical Societies convened at Hotel Continental Chicago, on December 2 for a Public Relations Conference.

Approximately 200 medical leaders from all parts of the United States heard the challenge facing Medicine from Arthur J. Altmeyer, Washington, D. C., Chairman, Social Security Board.

How the medical profession is answering the challenge was presented in three phases: "Expansion of Voluntary Group Medical Care Programs" was outlined by Joseph H. Howard, M.D., Bridgeport, President of the Connecticut State Medical Society; "Physician-Sponsored Legislation for Health Distribution" was presented by Philip K. Gilman, M.D., San Anselmo, President of the California Medical Association; "Modern Medical Public Relations" was diagrammed by O. O. Miller, M.D., Kentucky, Immediate Past President of the Kentucky State Medical Society.

"The Advantages of a National Health Congress" were outlined by John F. Hunt, of Foote, Cone & Belding, Chicago.

A round-table discussion, led by E. J. McCormick, M.D., Toledo, Chairman of the AMA Council on Medical Service and Public Relations, proved an interesting highlight of the day.

The commercial radio program of the Michigan State Medical Society was demonstrated, immediately following the talks. The day ended with a reception honoring the Presidents of the State Medical Societies.

Dr. Brunk was re-elected as President of the Conference of State Medical Society Presidents for the ensuing year.

MSMS Radio Hour, WJR, Detroit

OKLAHOMA POSTGRADUATE PROGRAM

The Oklahoma State Medical Association upon recommendation of the President, V. C. Tisdal, M.D., of Elk City, has adopted a progressive postgraduate program. All of the Councilor districts have been covered. The attendance and reception of the program has been most gratifying.

1. Public education through the press, radio, motion pictures, and a speaker's bureau.

(Continued on Page 1294)



Especially Processed **FOR GREATER EFFICACY**

TARBONIS, differing from other tar preparations, presents a new liquor carbonis detergens, produced by a process distinctly its own which results in high concentrations of sulfur compounds and unsaturated hydrocarbons—the ingredients to which the therapeutic efficacy of tar is credited. This unique liquor carbonis detergens is incorporated in a special vanishing-type cream which exhibits *all* the contained therapeutic substance to the area to which it is applied.

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**All the therapeutic value of tar in an odorless, greaseless,
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OKLAHOMA POSTGRADUATE PROGRAM

(Continued from Page 1292)

2. Postgraduate programs to the doctors of the state, refresher courses from the State Medical School, residencies, co-operation with the State Medical School in added facilities, including research facilities, for returning servicemen and civilian doctors.

3. Postwar planning for the placement of doctors now in the armed services.

4. Intimate contact between the State Association and County Medical Societies. (Details of this program are presented in the May *Journal* of the Oklahoma State Medical Association.)

A Speakers' Bureau has been organized consisting of more than 200 members of the medical profession. Sixty-two outstanding laymen, including the Governor, the President of the University, and the President of the Oklahoma A. & M. College, have agreed to participate.

MSMS Radio Hour, WJR, Detroit

VITAL STATISTICS

According to life insurance actuarial figures, the male infant born at the turn of the century could be expected to live 48.23 years. A girl baby born in 1900 had a life expectancy of 51.08 years.

In 1943, the latest year for which figures are available, the male child was born with a prospective life of 63.16 years, an increase of 14.93 years. The 1943 baby girl entered life with an expectancy of 68.27 years, 17.19 years longer than the girl child born in 1900.

In 1911, the death rate in the United States from tuberculosis was 224.6 per 100,000 population. Last year, the death rate from tuberculosis had dropped to 39.3 per 100,000. During that 33-year span, thousands of cases of tuberculosis were discovered by the x-ray in time for curative treatment.—AMERICAN COLLEGE OF RADIOLOGY.

The Board of Education at its last meeting authorized the acceptance by Wayne University of a gift from the Medical Science Center Corporation amounting to \$2,415.50. It will be used for the purchase of equipment in the department of anatomy at the College of Medicine.

"Forward steps in the neuropsychiatry treatments resulted in the return to duty in the theatre of operations of 90 per cent of the cases of battle fatigue. Forty to 60 per cent were able to return to combat units. Before the introduction of the new treatment, which occurs immediately behind the front, only 10 per cent returned."

Name

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Res. Add. City.....

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MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION

2020 Olds Tower, Lansing 8, Michigan, for the twelve-month period beginning September 19, 1945, the sum of

TOTAL PLEDGE	PAID HEREWITH	BALANCE DUE
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 or in annual payments of \$.....
 or (2) In War or Victory Bonds ☐ to be paid in the total sum ☐
 or in annual payments of \$.....
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 or (4) As a Memorial ☐ to the memory of:

 or (5) In my Will ☐

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Sleep insurance for doctors

To the harassed doctor, 'Dexin' brand High Dextrin Carbohydrate helps provide "sleep insurance"—nights made peaceful by fewer frantic calls from worried mothers. His 'Dexin' babies sleep more soundly, and are less subject to disturbances that interrupt slumber. The high dextrin content of 'Dexin' (1) diminishes intestinal fermentation and the tendency to colic and diarrhea, and (2) promotes the formation of soft, flocculent, easily digested curds.

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Literature on request



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DECEMBER, 1945

Say you saw it in the Journal of the Michigan State Medical Society

1295

Medical Veterans' Readjustment

VETERANS' ADMINISTRATION MEDICINE

In view of the suggestion made so frequently in these pages, and the belief of the Michigan State Medical Society that a more satisfactory method of care for the returning veteran would be in his home town and by his regular doctor, we are quoting the following from *The Washington Post*, Oct. 13, 1945:

"Veterans Administration and Monmouth County, N. J., are embarking on an experiment that promises to solve VA's acute doctor-nurse shortage in the large population centers, *The Post* learned yesterday.

"At the same time the program is aimed at setting up an adequate, flexible out-patient service for veterans whereby ex-GIs will be able to obtain treatment from their family physicians if they so wish.

"The plan was worked out after two years of study, by the Monmouth County Medical Society, and presented yesterday to Maj. Gen. Paul R. Hawley, VA acting Surgeon General.

"Here's how the plan will work.

"VA agrees to verify all county medical society members to treat veterans.

"The society's executive committee will select three screening clinics, each made up of five doctors. The veteran may select any doctor on the list he pleases. It is expected that in 85 per cent of the cases, the veteran can be treated as an out-patient at his home or in one of the five hospitals in the county. The rest of the cases will be sent to VA hospitals for long-period hospitalization.

Will Check Work

"A special disciplinary board will be set up by the medical society to pass on all complaints by the veterans, physicians or representative of VA and at the same time to pass on the doctor's bill and service.

"The participating doctors—90 per cent of the Society's 100-odd doctors have already agreed to join in the program—will be paid on the fee basis, the fee being based on the customary charge for that community.

"A VA liaison man will sit in at the screening clinics and okay the veteran then and there, at

least on a temporary basis, in order to slash away red tape. VA will provide clerical help to take care of the paper work.

"Thus under the Monmouth County Plan, a veteran will be treated as a member of his community rather than as a segregated individual. He will receive medical and hospital care within a reasonable distance of his home. Medical fees and expenses will be paid by VA.

"Under the present VA medical system, the out-patient service is virtually nonexistent. To receive treatment the veteran must enter a VA Facility, and remain in it to obtain treatment. Three community general hospitals, a tuberculosis hospital, and a State psychiatric hospital have agreed to co-operate with the medical society and VA in the program, which will benefit some 20,000 county veterans.

Will Aid Experiment

"For three months the screening committee, doctors and hospitals of the county will donate their services to VA. Participating doctors will accept the present VA fee schedule, although it is regarded as too low, until the experiment is accepted as a full-fledged activity of Veterans' Administration.

"General Hawley yesterday expressed gratification over the Monmouth County doctor's plan, and urged other counties and communities to offer their own programs for co-operating with VA in treatment of returning veterans. It is known that at least two other medical societies are considering presenting plans, one attacking the problem from the rural angle. (Michigan Medical Service and Michigan State Medical Society presented such plans on a state-wide basis.)

"The Monmouth County program is expected to be put on trial basis within a matter of days."

VETERANS' HOSPITALS

General Bradley, Administrator of Veterans' Affairs, announced on October 18, 1945, the locations of nineteen new hospitals, which are only part of the program.

(Continued on Page 1298)

Once a month dosage

... provides adequate prevention and treatment of **RICKETS**

Infron Pediatric

It is desirable to maintain antirachitic medication in children from infancy up to 14 years of age.

One capsule of Infron Pediatric administered once a month provides sufficient vitamin D for the prevention and treatment of rickets.

Infron Pediatric is readily miscible in the infant's feeding formula, milk, fruit juices, or water, and can also be spread on cereal. Each capsule contains

100,000 U.S.P. Units of vitamin D—Whittier Process—especially prepared for pediatric use.

Supplied in packages of 6 capsules—sufficient dosage for 6 months. Available at prescription pharmacies.

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NUTRITION RESEARCH LABORATORIES • CHICAGO

VETERANS' HOSPITALS

(Continued from Page 1296)

"The policy is to locate hospitals where the veterans will receive the maximum benefit from the most modern medicine and surgery of the type now available only to wealthy (or charity) patients at certain nationally known medical centers.

"Generally speaking, the benefit received depends primarily upon the type of medicine provided and not upon the buildings housing the patients. First-rate medicine can be provided only by first-rate specialists.

"There are insufficient topflight specialists available to staff expanding Veterans' Administration hospitals. Therefore, the services of this limited number of men may be obtained on a part-time basis only and only at the places where they are available, which are near the leading teaching centers. These are where the new large veterans' hospitals should be located if the maximum benefits are to be provided.

"Much of this new policy results from the number of veterans being about five times as great as before World War II. Where 4,000,000 veterans were potentially available before, there are now almost 20,000,000.

"This requires the policy to be to bring the veterans to the hospital itself, reversing the World War I idea of bringing the hospital to the veterans.

"This does not entail, however, the abandonment of existing hospitals or preclude the building of small local hospitals for the convenience of veterans and visiting families. It will provide a type of treatment which may well mean the difference between recovery or death for thousands of seriously ill or injured veterans.

"The interests of the veterans themselves, rather than of communities desiring veterans' hospitals, required the adoption of the present policy."

PROSTHETIC AND SENSORY DEVICES

Major General Paul R. Hawley, Acting Surgeon General of the Veterans' Administration, announced, October 26, 1945, that:

The Veterans' Administration will take over on January 1, 1946, all of the development and research work being conducted on prosthetic and

sensory devices (artificial limbs, hearing aids, dentures, etc.) by the Office of Scientific and Research Development, a wartime agency which is scheduled to go out of existence December 31. In addition, the Veterans' Administration will assume on January 1, 1946, the Army's experimental work in these fields in connection with the OSRD and the National Academy of Sciences.

This means that the Veterans' Administration will become the central Federal agency for all research and development work on prosthetic appliances, a step that has been advocated by some Congressional and other sources, so that all Government as well as outside agencies may benefit from the results of a unified program.

Arrangements are now being made with the Bureau of the Budget to transfer the existing research contracts, effective January 1, 1946, to the Veterans' Administration so that this work may be continued on an uninterrupted basis. It is estimated that the work will require \$1,000,000 per year.

The original research and development work on artificial limbs and other prosthetic and sensory devices was initiated through a Special Committee on Prosthetic Devices, headed by Dr. Paul E. Klopsteg. It was established by the National Research Council on March 20, 1945, to conduct an intensive campaign in this field, which resulted in many excellent results. In addition to the OSRD program, the Veterans' Administration has been conducting limited experimental and development work at its hospital in the Bronx, N. Y.

It is emphasized, however, that the permanent research and development program is concerned only with the long-range future aspect of the problem. In other words, it seeks to develop the best and most modern appliances and does not include instruction as to their actual and immediate usage.

To meet this vital phase of the problem, the Veterans' Administration has formulated plans for an immediate research and educational program to teach the disabled veteran to properly use artificial limbs or other prosthetic and sensory appliances as quickly as possible. Leading specialists in this field will be employed to supervise the activities. A formal announcement will be made as soon as key personnel have been selected to head the program.

(Continued on Page 1302)



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good to me, mister?"...***

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The soft-curd characteristics of Biolac assure ease of digestion. Adjusted milk fat content facilitates digestion and assimilation, with greater freedom from fat upsets; ample lactose assures soft, natural stool formation; and a high protein level contributes to optimal growth and health.

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Illustrated is the sulfathiazole-frosted pharynx of patient A.K., *two hours* after Paredrine-Sulfathiazole Suspension had been instilled intranasally.

WHY SUCH RAPID RELIEF

TO OBTAIN BEST RESULTS . . . the sore throat patient should not eat or drink fluids for one or two hours after instillation of Paredrine-Sulfathiazole Suspension. He should also make every effort to reduce nose-blowing and throat clearing to a minimum.

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N SORE THROAT ?

Sulfathiazole is particularly effective against the hemolytic streptococcus, which apparently causes the vast majority of sore throats.

There are two other important reasons why Paredrine-Sulfathiazole Suspension—when administered intranasally—is so successful in the treatment of acute nasopharyngitis:

- 1 Part of the Suspension remains beneath the middle and superior turbinates—and, mixing with sinus drip, retards the proliferation of bacteria before they reach the nasopharynx and intensify the infection.
- 2 Part of the Suspension drifts downward over the nasopharynx, forming a fine frosting on the nasopharyngeal mucosa. This thin blanket not only keeps producing a bacteriostatic solution at the site of infection, but also appears to provide marked surface analgesia.

PAREDRIINE-SULFATHIAZOLE SUSPENSION

vasoconstriction in minutes

bacteriostasis for hours

(Continued from Page 1298)

ALL QUALIFIED PHYSICIANS . . . TO TAKE CARE OF VETERANS

Major General Paul R. Hawley of the Veterans' Administration, in an article in JAMA of October 13, stated these encouraging words:

"It is impossible to undertake the medical care of the veteran, with a permanent, full-time, paid corps of medical persons . . . no attempt will be made to build up a large permanent organization.

"It is a matter of law that the veterans go to a Veterans' physician, but there is nothing in the law to say that all qualified physicians in a community cannot be designated to take care of veterans.

"Perhaps a Committee could simplify the paper work so as to make it less burdensome for the men who undertake the work.

"One great trouble with the Veterans' Administration has been its centralization. The administrator is now decentralizing the administration to 13 districts.

"I should like to see veterans' hospitals built in such a way that, as their need for the care of veterans decreases, they can be fitted into the need of the people as a whole. In the years to come they could perhaps be turned over to communities. I am in favor of the care of the veteran in the existing civilian institutions to the greatest possible extent."

REMISSION OF DUES AND ASSESSMENTS OF MILITARY MEMBERS

Medical veterans, members of the Michigan State Medical Society, who return in 1945 will be accorded remission of MSMS dues and assessments for the balance of 1945 and for all of 1946.

For those medical veterans returning during the first six months of 1946, all 1946 MSMS dues and assessments will be remitted.

For medical veterans returning during the last half of 1946, dues and assessments for the remaining months of 1946 plus all of 1947 MSMS dues will be remitted.

This arrangement was ordered by the Executive Committee of The Council at its meeting of November 8, 1945.

HOME-OFFICE CARE AND EMERGENCY HOSPITALIZATION OF VETERANS

"Resolved, That the doctors of medicine of the State of Michigan urge that the Veterans' Administration avail itself of the medical services of all the doctors of medicine of Michigan through Michigan Medical Service; and that the provisions of this resolution be used in whatever manner deemed proper by The Council of the Michigan State Medical Society."—Adopted by 1945 MSMS House of Delegates.

Pursuant to this resolution, the MSMS Council has negotiated with the Veterans' Administration looking to the use of the family physician in the care of the returned veteran, channeling the fiscal arrangements through Michigan Medical Service. Representatives of

the State Medical Society and of Michigan Medical Service made preliminary contacts with General Hawley of the Veterans' Administration in Chicago in October and in Washington, D. C., in November.

A progress report on this project will be presented to the membership through the pages of *The Journal* and in the Secretary's Letter.

The efforts of the Michigan State Medical Society are focused toward the preservation of the physician-patient relationship in the care of the veteran.

SPECIFIC BENEFITS UNDER GI BILL OF RIGHTS

Many factors enter into the decision regarding benefits to which a veteran is entitled, such as his age at the time he entered service, disability, etc. For this reason general information on benefits which are due a veteran under the Servicemen's Readjustment Act of 1944 (the GI Bill) may not be sufficiently specific to satisfy the inquirer. Exact information in each individual case may be obtained by contacting E. A. Jones, Chief of Vocational Rehabilitation Section, Veterans' Administration, Dearborn, Michigan.

RESOLUTIONS RE MEDICAL VETERANS ADOPTED BY MSMS HOUSE OF DELEGATES

The 1945 MSMS House of Delegates adopted a number of important resolutions relative to medical veterans. These will appear in full in the Proceedings of the House of Delegates, published in the November-December Numbers, JMSMS. The following résumé of four of these resolutions indicates the great interest of the House of Delegates in the solution of problems affecting medical veterans who return to Michigan:

1. That pertinent information be published from time to time in JMSMS, and be readily accessible to the component county societies and to all discharged veteran doctors of medicine; that the Postwar Planning Committee of the various county societies co-operate with the State Society in assembling data for use by the county and state organizations; that data be collected on residencies, refresher courses, locations to practice, methods of securing loans to establish practice or for educational purposes, and all other matters pertinent to the problems of the returned veteran doctor of medicine.

2. That the MSMS House of Delegates requests Michigan members of Congress to work for an amendment to the Servicemen's Readjustment Act of 1944 to the end that the full tuition for all courses of education of less than 30 weeks be paid by the government for veterans, provided such payments to any one person do not exceed \$500 within any single year.

3. That the House of Delegates of the Michigan State Medical Society strongly urges that every doctor of medicine in the armed forces who can possibly be spared and whose duties are not essential to the health

(Continued on Page 1304)



Expanding —

The rapidly increasing demand for Pitman-Moore Biologicals has compelled us to launch an extensive new building program.

With the completion of a large addition to the main building of our Biological Laboratories, increased capacity has been provided for vaccine production, serum processing and control testing.

Construction has also just begun on a new building to house laboratory-test animals, including thousands of additional white mice, hamsters, guinea pigs, dogs, cats and other

animals essential to safeguarding the potency, purity and safety of finished products.

Pitman-Moore look forward to an ever expanding program of service to the medical profession through the medium of the Biological Laboratories at Zionsville, Indiana, as well as the Pharmaceutical and Research Laboratories at Indianapolis.

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Another First For Michigan

The phrase, "Another First for Michigan," has become a by-word in medical circles outside this State. Few members of the Michigan State Medical Society realize the enviable reputation for pioneering which their organization enjoys throughout the land.

A list of "Firsts" sponsored by the Michigan State Medical Society within recent years will explain why Michigan holds a commanding position of leadership among State Medical Societies.

1. Michigan Medical Service, the first professionally sponsored voluntary medical care plan based on "service" which reached the half million mark—now 868,498 subscribers.

It is to be noted that Michigan Medical Service was sponsored and is controlled by the medical profession of Michigan.

2. Outstanding postgraduate medical education program, in which extra-mural courses are brought by eminent teachers to doctors in their home communities.

3. Creation of Michigan Foundation for Medical and Health Education, and the organizing of a campaign to bring this Foundation to a goal of \$150,000 in the next year.

4. Commercial radio program (over WJR every Friday evening).

The Michigan State Medical Society has expended over \$27,000 on the first three series of this radio program. Series IV began October 12, 1945.

5. Industrial health conferences, annually, to bring to industrial surgeons and medical men in general the latest advances in this specialty and also to bring a better understanding between the general man and the physician who specializes in industrial medicine or surgery.

6. Inauguration of Detroit Public Relations Conference to which the Presidents of 17 eastern and middle-eastern states were invited (April, 1945) to discuss better public relations on behalf of the medical profession and the people it serves.

7. Development of "Outline" for needed medical legislation by a Drafting Committee on Legislation, for submission to governmental agencies by and through the AMA Council on Medical Service and Public Relations.

8. Michigan Rheumatic Fever Control Conference (September, 1945).

Also the formation of rheumatic fever diagnostic and consultation centers in strategic parts of the state, to interest more physicians in rheumatic fever and to aid in control of this disease.

9. Medical Veterans Readjustment Program, created by the Michigan State Medical Society to aid the returning medical veterans in matters of postgraduate education, relocation, and finances.

10. Development of Uniform Fee Schedule for Governmental Agencies, based on the conception that the minimal fee for medical work performed for governmental agencies shall be commensurate with the work done.

11. Cancer Detection Clinics, organized through the efforts of the MSMS Cancer Control Committee.

Publication of a "Cancer Manual," an outstanding work in cancer control.

12. Organization, together with Michigan Hospital Association and the two service plans (Michigan Medical Service and Michigan Hospital Service) of the Michigan Health Council, a non-governmental organization to advance the health of the people.

13. Stimulation for creation of a "National Health Congress" to co-ordinate and encourage efforts along socio-economic lines by state medical societies, state dental societies, state or district hospital associations, state or district pharmaceutical associations, and the other groups interested in maintenance of the voluntary type of medical service.

ADEQUATE HEALTH SERVICE

A. J. Altmeyer says:

The Government needs the help of the medical profession in achieving this objective and, in my opinion, the medical profession also needs the help of the Government.

CENTRAL STATES DERMATOLOGICAL SOCIETY

The next meeting of the Central States Dermatological Society will be held in Detroit, Michigan, at Harper Hospital on April 27, 1946. Clinics will start at 2:00 P.M. on that day.

For further information communicate with Dr. C. R. Reyner, Secretary-Treasurer, Henry Ford Hospital, Detroit, Michigan.

RESOLUTIONS RE MEDICAL VETERANS

(Continued from Page 1302)

and care of our own military personnel be released from service with the least practicable delay.

4. That the House of Delegates of the Michigan State Medical Society commend the Senate of the United States on its resolution No. 134, to create a subcommittee of the Senate Military Affairs Committee to investigate the disparity between the ratio of civilian doctors to the population as compared with the ratio of medical officers to soldiers, and the House of Delegates urges that every effort be made to expedite the return to civilian practice of every medical officer who can be spared from military service without endangering the lives or health of our armed forces."



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THE prompt symptomatic relief provided by Pyridium is extremely gratifying to the patient suffering with distressing urinary symptoms such as painful, urgent, and frequent urination, tenesmus, and irritation of the urogenital mucosa.

Pyridium is convenient to administer, and may be used with complete safety throughout the course of cystitis, pyelonephritis, prostatitis, and urethritis. *The average oral dose is 2 tablets t.i.d.*

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For gratifying relief of
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Legislative Pattern for Health Care

At the Detroit and Denver Medical Public Relations Conferences, the President of the Michigan State Medical Society was requested to draft an Outline of Legislation which would help provide better health care for all the American people. President A. S. Brunk, M.D., called upon the states represented at the two Conferences to submit statements of principles from which a Composite Outline could be developed. Such a composite was formulated by the Drafting Committee on Legislation of the Michigan State Medical Society, based on principles developed by ten state medical societies. The Composite Outline was submitted to the Chicago Conference of Presidents of State Medical Societies on December 2.

The Composite Outline follows:

PREAMBLE

To provide better health care for all the American people, we submit the following principles:

PRINCIPLES

1. Establishment in the President's Cabinet of a Secretary of Public Health and Medical Welfare, who shall be selected from the ranks of actively practicing physicians, and under whose jurisdiction every federal

bureau and office, whose duties are related to health and medical welfare, shall be grouped.

2. Encouragement of medical and scientific research and study for the continuous improvement of medical care, by government grants-in-aid to public and private institutions.

3. Provide federal or state grants-in-aid, or loans, for the expansion of hospital facilities, the operation of same to be entirely supervised, controlled, and carried on by state, county, municipal, or private administration.

4. Establish state-wide voluntary non-profit health care programs in every state, based on the free choice of purveyors of health care; such programs shall act as a service plan to all in groups classified as within a specified income level as determined by the plan in each state or regional unit; as an indemnity plan for those classified as above that income level by each state or regional unit; as a service plan to the indigent and semi-indigent by contractual arrangement for payment of charges from county, state, or federal funds; as a service plan for all other governmental categories eligible for health care; as a service plan for all physicians' services to veterans of the armed forces for all illnesses or disabilities; further federal or state programs for expansion of medical service to be developed within the structure of the above-described program.

All state-wide medical care programs on either a service or indemnity care basis shall be incorporated under special state enabling acts or by already existing state statutes relating to non-profit producers' co-operatives. This will provide for either a pre-payment or a reimbursement contractual service.

Group co-operation and reciprocity, on a national level, by all voluntary state medical and hospital care (Blue Cross) programs, should be accomplished.

MICHIGAN MEDICAL SERVICE ENDORSED BY MSMS HOUSE OF DELEGATES

"WHEREAS, Michigan Medical Service has provided the means whereby almost one million people in this State have been able to secure good medical care on a voluntary budgeted basis; and

"WHEREAS, This medical care has been rendered in a manner which has been generally highly satisfactory to both physician and patient; and

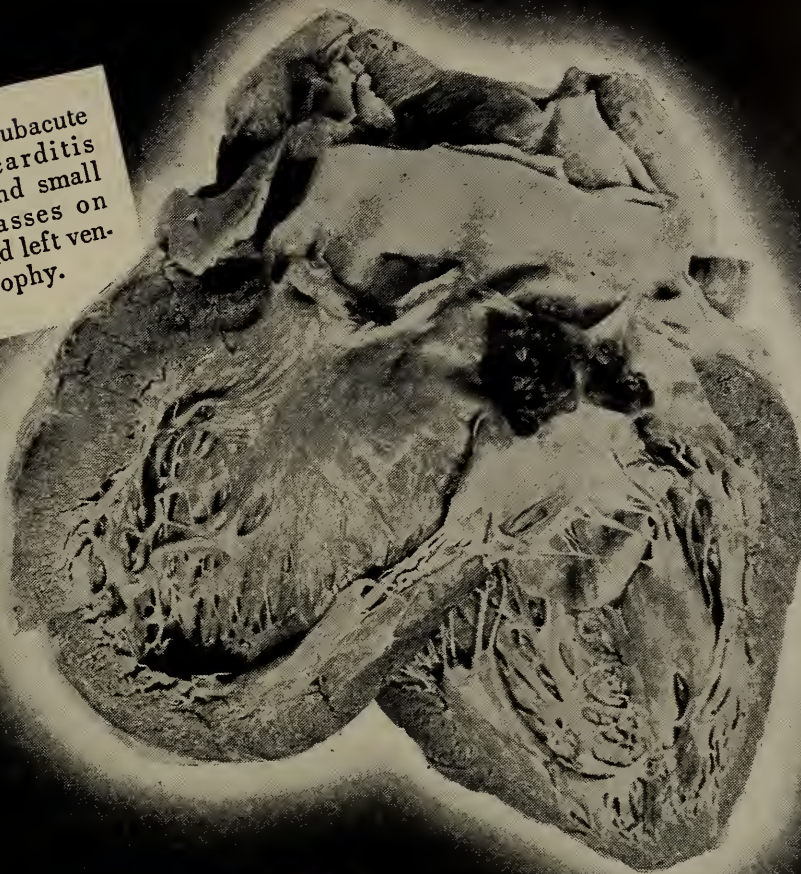
"WHEREAS, This has resulted in better feeling and understanding between the public and the medical profession; and

"WHEREAS, The voluntary type of group medical service, as exemplified by Michigan Medical Service, is to be preferred—in the interest of the peoples' health—to compulsory schemes and political control; therefore be it

"RESOLVED, That the House of Delegates of the Michigan State Medical Society urgently request every doctor of medicine in this state to recognize the value to his patients and to himself of Michigan Medical Service, that every physician endorse the service and become a subscriber (policy owner) thereof, and further, that every practitioner of medicine constantly spread the word concerning the advantages of the voluntary, medical-society-sponsored program of group medical care to all his patients, friends and acquaintances, to the end that the protection of Michigan Medical Service is available to all persons in this State, thus obviating any desire or need for bureaucratic medicine."

Adopted unanimously at Detroit Session, September 18, 1945.

Typical heart of subacute bacterial endocarditis showing large and small thrombotic masses on aortic valves, and left ventricular hypertrophy.



PENICILLIN

... IN SUBACUTE BACTERIAL ENDOCARDITIS

Penicillin is the best agent available for the treatment of this devastating disease. Although in a few instances it may be desirable to use the continuous intravenous route, intramuscular injection is the one of choice. If best results are to be obtained 200,000 to 300,000 units should be given daily for three weeks or longer. (Keefer, C. S. et al.: New Dosage Forms of Penicillin, J. A. M. A. 128:1161, Aug. 18, 1945.)

Bristol Penicillin, because of its low toxicity and freedom from pyrogens, as well as its absolute sterility and standard potency, provides dependable therapeutic action.

The rapidly developing new clinical uses of this potent antibiotic are abstracted in issues of the *BRISTOL PENICILLIN DIGEST*. If you are not receiving *your copies* regularly, drop us a line.

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Juris ignorantia est, cum jus nostrum ignoramus—OLD MAXIM

NOTES ON COURT DECISIONS, STATUTES AND OTHER AUTHORITIES

J. JOSEPH HERBERT, LL.B., General Counsel, MSMS
Manistique, Michigan

NARCOTIC PERMITS—CHIROPODISTS—LOCAL ANESTHETICS— PHYSICIANS

Fowler vs. Michigan Board of Pharmacy
312 Mich. 505

The question as to whether persons other than doctors of medicine and osteopaths are entitled to narcotic permits was for the first time decided by the Supreme Court of Michigan in the very recent case of Fowler vs. Michigan Board of Pharmacy, 312 Mich. 505.

In 1937, our legislature adopted the Uniform Narcotic Drug Act, Section 1 of which defines physician as "a licensed practitioner of medicine or osteopathy as defined by law in this State and any other person authorized by law to treat sick and injured human beings in this State and to use narcotic drugs in connection with such treatment."

Section 7 of the Act allows "physicians" to prescribe, administer and dispense narcotic drugs.

The Michigan State Chiropodist Act authorizes persons who have been licensed by the Board of Registration in chiropody to treat "medically, surgically and mechanically or by physiotherapy, ailments of the human foot" but specifically states that chiropodists shall not "amputate the human foot or toes or use or administer anesthetics other than local."

Prior to 1943, chiropodists were able to procure narcotic licenses from the state. In 1943, however, the Attorney General issued an opinion to the Director of Drugs and Drug Stores, holding that there was no authority under the chiropody act which would give a chiropodist the right to use narcotics in the course of his practice, and that the right to administer a local anesthetic limited chiropodists to the use of several substances used in local anesthesia, such as butaline or 2 per cent novocain, evidently claimed to be non-narcotic.

Thereafter, the state refused to issue narcotic licenses to chiropodists and the Federal government likewise refused to register or issue narcotic permits to chiropodists under the Harrison Act.

In 1944, the plaintiffs, licensed chiropodists, brought suit in the United States district court against the Federal officials to compel their registration and licensing under the Harrison Act. The district judge sustained the contention of the chiropodists, holding that the plaintiffs were entitled to be registered and to be issued permits under the Federal law. From this decision the government took an appeal to the Circuit Court of Appeals. That court took the position that unless chiropo-

dist are licensed by the state to prescribe, administer or dispense narcotic drugs they could not be issued permits under the Harrison Act. *Kavanagh vs. Fowler*, 146 F (2nd) 961.

The plaintiffs then brought suit in the Supreme Court of Michigan to mandamus the state board of pharmacy and the director of drugs and drug stores to issue them narcotic licenses.

The respondents, represented by the attorney general, contended that the legislature did not intend to include chiropodists in the State Narcotic Drug Act and that the authorized use of local anesthetics by chiropodists is limited to non-narcotic substances.

The court, however, was not persuaded by the reasoning of the attorney general and in sustaining the position taken by the plaintiffs said, "The attorney general relies on the familiar maxim 'expressio unius est exclusio alterius,' and contends that inasmuch as the chiropodists are not mentioned in the act, which specifically mentions physicians, dentists and veterinarians, it was the intention of the legislature not to include chiropodists. He overlooks the broader definition of physicians in the act. The chiropodists are called upon to perform many operations such as removal of ingrowing nails, growths, and callosities on the foot, manipulation of the bones of the foot, et cetera, all of which would cause tremendous pain to the patient were anesthetics not used. We have held that a chiropractor may practice medicine within the limits of the chiropractic act, but in doing so he does not become a licensed physician, surgeon or doctor. *Erdman v. Great Northern Life Ins. Co.*, 253 Mich. 579. The narcotic act and the chiropody act taken together indicate that a chiropodist may use local anesthetics. If 'local anesthetics' do not include the use of narcotics, why did the legislature in section 2 of the chiropody act state that the certificate of qualification or license of the chiropodist does not authorize him to use anesthetics other than local? No limitations as to local anesthetics would have been necessary for, if the State is correct, local non-narcotic anesthetics may be used by anyone and there would have been no occasion for the law to mention it. We believe local anesthetic means, as defined

(Continued on Page 1316)



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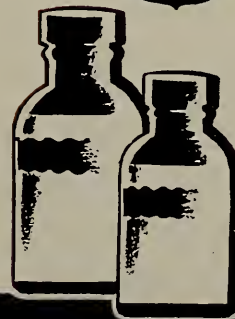
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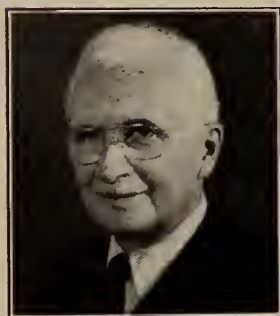
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The Michigan Foundation for Medical and Health Education—designed to promote medical research, undergraduate and postgraduate studies in medicine and general health education among the public—was incorporated September 21, and seeks an ultimate endowment of \$500,000 to \$1,000,000.

The Medical Foundation has created an instant appeal. Additional gifts are being made almost daily to the Foundation, which is a non-profit corporation which will function under the interest from its endowments.



J. M. ROBB, M.D.
Trustee

The Board of Trustees elected E. I. Carr, M.D., of Lansing, as President of the Foundation.

B. R. Corbus, M.D., Grand Rapids, was chosen as Vice President; Wm. J. Burns, Lansing, was elected Secretary; and Herbert H. Gardner, President of the Birmingham National Bank, was made Treasurer.

Trustees include both physicians and laymen. The

Doctors of Medicine are: Drs. Carr and Corbus; James D. Bruce, M.D., Ann Arbor; Wm. A. Hyland, M.D., Grand Rapids; J. M. Robb, M.D., Detroit, and R. H. Stevens, M.D., Detroit. Besides Treasurer Gardner, the laymen include Ernest H. Fletcher, Detroit, and Harry G. Gault, of Flint.

Impetus to the Foundation's creation came in September when A. S. Brunk, M.D., Detroit, retiring Presi-

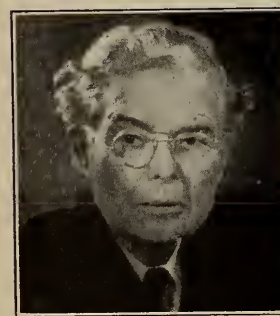
dent of the Michigan State Medical Society, advocated the plan and offered a \$1,000 donation if ninety-nine other persons in Michigan would make similar gifts within a year; this \$100,000, together with amounts pledged and contributed to the former Postgraduate Foundation of the state medical society, would give a potential endowment of \$150,000 within a year.

Contributors for the Michigan Foundation for Medical and Health Education, since its incorporation, are:

\$1,000 each from J. D. Bruce, M.D., Ann Arbor; A. S. Brunk, M.D., Detroit; Earl I. Carr, M.D., Lansing; C. V. Costello, M.D., Holland; H. H. Cummins, M.D., Ann Arbor; E. E. Fletcher, Detroit; L. J. Gariepy, M.D., Detroit; L. J. Hirschman, M.D., Detroit; Wm. A. Hyland, M.D., Grand Rapids; Joint Committee on Health Education, B. R. Corbus, M.D., Grand Rapids, Chairman; Francis Jones, M.D., Lansing; Kent County Medical Society; Mrs. F. B. Miner, Flint, in memory of the late F. B. Miner, M.D.; Harold L. Morris, M.D., Detroit; Lawrence Reynolds, M.D., Detroit; J. M. Robb, M.D., Detroit; G. B. Saltonstall, M.D., Charlevoix; Clair L. Straith, M.D., Detroit; Ralph Wadley, M.D., Lansing; John O. Wetzel, M.D., Lansing; E. R. Witwer, M.D., Detroit. E. F. Sladek, M.D., Traverse City, pledged \$5,000, and Michigan Medical Service contributed \$10,000. Total, \$36,000.



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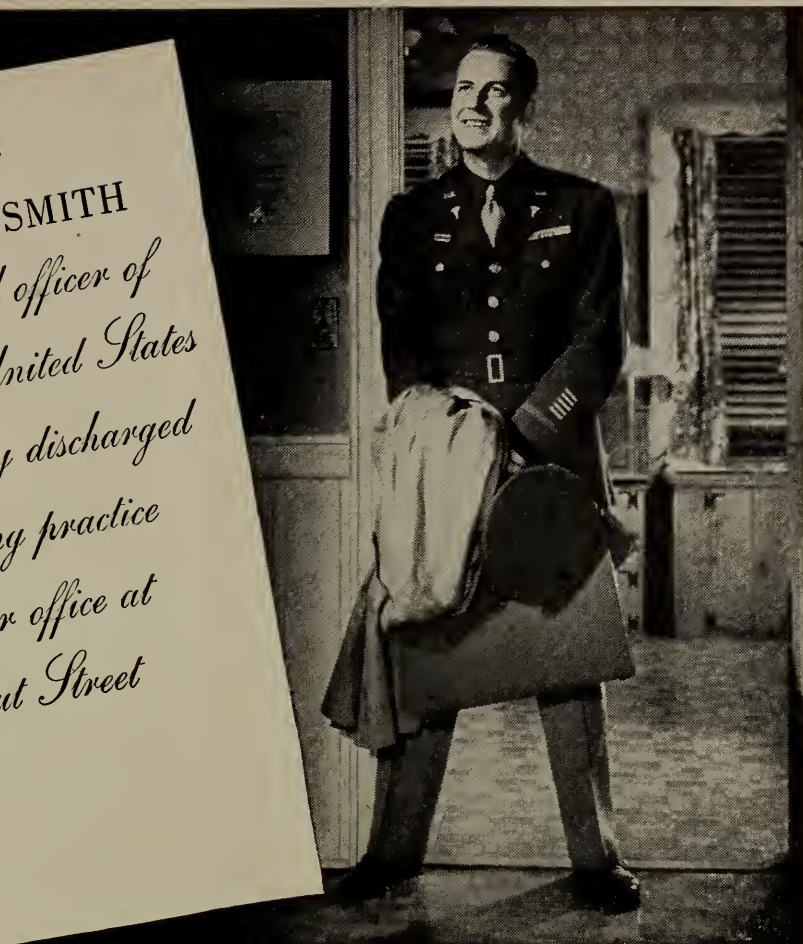
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Editorial Opinion

WE CARRIED THE TORCH

Pearl Harbor Sunday struck a United States peaceful, quiet, and church-going, and roused it to instantaneous fury, complete unity, and ferocious efficiency. Our immortal President threw the switch, the wheels of the Government churned, and ships, jeeps, armament and aeroplanes all but clogged the runways. America overnight was at war, determined to win the greatest war in history. Industry, Labor, Capital, Inventive genius, and eleven million of its citizenry, men and women, surged to arms.

Peacetime America's Medical Profession consisted roughly of one hundred and thirty thousand men and women—or again roughly 1/10 of one per cent of its citizenry—small, but sufficient to give our country the grandest health record, lowest morbidity, and most envied longevity in all the world. The Surgeon General called for doctors, and like sheep on our western plains they stampered their way into their country's service. Interns left an incompleated hospital service; young men and women with a budding practice; middle-aged practitioners with valuable experience, health, vigor and ambition. Men of fifty tightened their belts to hide the tell-tale paunch of years. Men in their fifth and sixth decades of life, grey haired, bald, with national and international reputations, left children and grandchildren to give freely and gladly to their country which had given them so much.

Into the Armed Services they thronged—ten, twenty, thirty, forty thousand strong. Like the Minute Men of Lexington they rushed forward to hold the line! And what were they able to give to the eleven million gallant men and women fighting for Liberty and Democracy? The sulphadiazines; penicillin; newer methods of surgery; the latest in diagnostic skill? Aye and more—vastly more! They gave their life's blood, countless hundreds of them, on the battlefields, in the air and on the seas, but they gave to this vast Army of ours again the lowest death rate and the highest recovery rate of any army in history.

In the meantime the medical profession at home, depleted not only by 40 per cent, but by the most virile 40 per cent, carried on with its routine civil practice. Men and women in our profession found physically unfit for the rigors of military service buckled down to double duty—their own and that of a departed professional buddy. Old men, sixty, seventy and eighty years old, came back into active practice once more. Out came, too, the coughing, sputtering old automobile with its worn tires; but armed with a

"C" sticker it traveled the country roads and the city streets by day and by night.

Throughout the land they chanted the slogan, "Carry the Torch." They took their food and their sleep as they found it, wiped their bleary eyes, grinned and said: "It won't be for long. The youngsters will be along soon. 'Carry the Torch.'"

The most disturbing note to the "oldsters" was not the course of the War—the German war was won, the Japanese practically so. Another attack was in the offing—a Legislative one. The United States of America, which had raised two hundred billion dollars without even a disturbing economic ripple, to wage the most stupendous and successful war in history, was now concerned about the ability of its citizenry to meet its obligations, if and when it needed medical aid. The Murray-Wagner-Dingell Bill, up for consideration, was about to change the entire complexion of the practice of medicine. And the "oldsters" were confused, depressed and concerned. How could they "Carry the Torch" for the young 'uns on this vital issue?

Some of the Young Uns had given up their lives in France, Germany, Okinawa, and far distant places, and the remaining thousands were plenty occupied taking care of the sick and wounded. And yet the old slogan was there, "Carry the Torch." So the oldsters scratched their grey and bald heads, and as rapidly as possible organized throughout the land, in their various and separate states, "Voluntary Prepayment Plans for Medical and Surgical Services," and "Prepayment Plans for Hospital Care," to meet the needs of the vast number of men and women of moderate means. And they worked as busily as ants building their house, to offset a dangerous and pernicious national program of health control. "Carry the Torch." "Carry the Torch!"

And now the oldsters of the medical profession of these United States make this homely plea: "Mr. President of the United States, Mr. Senator and Mr. Representative, if you please:

We, the old and physically unfit members of the Medical Profession who have borne the double burden during the past four years since Pearl Harbor, we beg of you, don't legislate our forty-five thousand "youngsters" who are still on the battlefields out of the type of Practice of Medicine they left and loved; wait until they come home to discuss this with you. In the meantime if our plan of

(Continued on Page 1316)

Advances in the therapy and care of arthritic patients have considerably increased their chances for recovery

Many factors have aided in this improved prognosis in arthritis. Patients are seeing their physicians earlier, when more rapid improvement can be expected. The physical and dietetic care of the patient is now better understood. Greater cooperation of the patient is obtained by education, and in general a more scientific approach to the problems is made.

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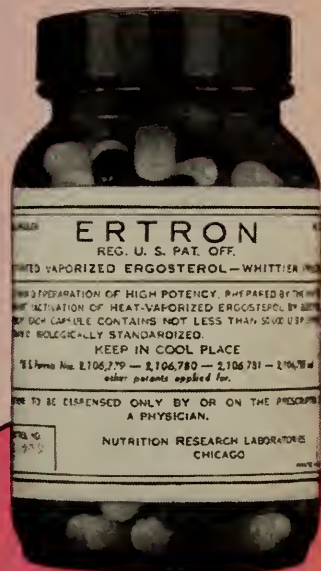
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Political Medicine

POLITICAL MEDICINE

Lest we forget, and take too little forethought;

That we may remember what happened at the last legislature;

That we may be prepared for future trials:

Let us consider the following abstract from "Michigan CIO Legislative Report 1945." Every member should read it, then consider the means to protect our sacred and time-honored independent Practice of Medicine. We are not even accorded the privilege demanded by CIO of having a word at least to say of the conditions under which we shall work.

"HEALTH INSURANCE—This question is being approached on both the National and the State level. Several states considered it during their legislative sessions this year. Congress may act first. While it seems preferable that this be done on a National basis, labor cannot place all of its eggs in one basket by depending upon Congress.

"Pressure must be brought to bear for a good State Health Insurance Act. If the Legislature does not give serious consideration to this problem; the program outlined by our last State Convention whereby the Constitution was to be amended by referendum, will be the only avenue open.

Labor made an attempt this year by the introduction of two bills, but more general public support is necessary. A CAMPAIGN MUST BE SPONSORED TO BREAK DOWN THE MEDICAL PROFESSION. The inadequacy of our present medical care system is perfectly obvious when one considers that 35 per cent of the youthful male population of the nation were turned down for military service because of physical unfitness." (Pages 27-28.)

Note again the absolutely unfair and untrue claim that the present method of medical care accounted for 35 per cent of the youthful population of the nation being turned down for military service because of physical defects.

EXPLORE THE DETAILS FIRST

Probably one of the reasons why Congress has been slow to include compulsory health insurance legislation such as proposed in the Wagner-Dingell Bill as part of the Federal social security program, is the problem of cost in proportion to benefits. The Wagner-Dingell Bill specifically provides that social security payroll taxes be raised to a total of 8 per cent, half to be paid by the employer and half by the employee. Of the 8 per cent, 4 per cent is intended to defray the expense of medical care, hospitalization, and temporary disability. Thus the wages of a person earning \$225 per month would be subject to a total social security tax of \$216 annually, half of which would be deducted directly from the salary check. One hundred and eight dollars of the

\$216 would be for medical and temporary disability protection.

How does *this compare* with the *cost* of accident, health and hospitalization insurance in government-regulated insurance companies in group form?

Here is what can be *purchased* for \$39 per year; \$30 weekly benefits for illness and accident; \$5 daily hospital benefit for a 70-day period, plus \$25 for laboratory medicines, x-ray and other charges, plus up to \$150 reimbursement for surgical expenses. Hospital benefits are paid for 70 days just as many times in a year as the employe may need them. Also, when a contract is *purchased* from a *private company*, it cannot be changed by the insurance company as long as payments are made. Any government insurance plan may be changed at the will of Congress. These are but a few of the *details* that should be *explored* before the country goes overboard for *state medicine*.—Editorial, *Ludington Daily News*, October 18, 1945.

IT'S THE LAW, DOCTOR

(Continued from Page 1308)

in Dorland's *American Medical Dictionary* (Rev. 1941): "That which is confined to one limited part of the body."

"The agency employed to bring about such anesthesia is not restricted by the law. This seems to us to be a far more reasonable interpretation of the law, and we so hold. If the legislature had any other intention, and we believe not, the law can be readily amended at the next session."

It should be of interest to the medical profession to note that in statute law, at least, the word "physician" has no categorical or inflexible meaning. Acceptation or even a dictionary definition is not a reliable guide if the legislature chooses to redefine a word. And so, we have here a case in which by legislative fiat a chiropodist becomes a physician.

EDITORIAL OPINION

(Continued from Page 1312)

voluntary prepayment seems to you learned gentlemen inadequate, if it does not reach quite all of our citizens, subsidize that minor percentage. The cost would be so small compared to what we have become accustomed to—and wait, please, until we, your Medical Profession, are once again united 130,000 strong, so that we 'oldsters' may in truth be able to strut, grin, hold up our chins, and as we clasp the hands of our young 'uns be able to say: 'We Carried the Torch.'"—ROBERT S. BERGHOFF, M.D., F.A.C.P., in *Chicago Medical Society Bulletin*, August 25, 1945.

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War Medicine

QUALIFIED RESERVE OFFICERS TO RECEIVE PROMOTION

Qualified reserve officers who have not yet received a promotion while on active duty will receive one promotion as they are separated, the War Department has announced. To be eligible for this promotion, the officer must have served two years in his present rank since September 16, 1940, and must have an efficiency rating of at least 35. This does not apply to promotions above the rank of Colonel.

DOCTORS IN SERVICE

General Bliss, on October 15, 1945, stated that in proportion to the Army's 45,000 doctors on V-E Day, there are now 43,000 in service, 2,000 of whom are recent graduates of medical schools. With the high hospital load in this country, a large number of doctors are needed to staff hospitals and separation centers, which are now at peak operation. These centers require a total of 2,000 doctors.

General George C. Marshall says: "The remarkable reduction in the percentage of the deaths from battle wounds is one of the most direct and startling evidences of the great work of the Army medical service. In the last two years Army hospitals treated 9,000,000 patients; another 2,000,000 were treated in quarters and more than 80,000,000 cases passed through the dispensaries and received outpatient treatment. This tremendous task was accomplished by 45,000 Army doctors assisted by a like number of nurses and by more than one-half million enlisted men, including battalion-aid men, whose courage and devotion to duty under fire has been as great as that of the fighting men they assisted.

"Despite the fact that United States troops lived and fought in some of the most disease-infested areas of the world, the death rate from nonbattle causes in the Army in the last two years was approximately that of the corresponding age group in civil life—about 3 per 1,000 per year. The greater exposure of troops was counterbalanced by the general immunization from such diseases as typhoid, typhus, cholera, tetanus, smallpox, and yellow fever, and, obviously, by the fact that men in the Army were selected for their physical fitness.

"The comparison of the nonbattle death rate in this and other wars is impressive. During the Mexican War, 10 per cent of officers and enlisted men died each year of disease; the rate was reduced to 7.2 per cent of Union troops in the Civil War; to 1.6 per cent in the Spanish War and the Philippine Insurrection; to 1.3 per cent in World War I; and to 0.6 per cent of the troops in this war.

"To insure that men are properly prepared for return to civilian life the Army established 25 special convalescent centers. At these centers men receive not only highly specialized medical treatment, but have full opportunity to select any vocational training or recreational

activity, or both, they may desire. Men, for example, who have been disabled by loss of arms or legs are fitted with artificial limbs and taught to use them skillfully in their former civilian occupation or any new one they may select. Extreme care is taken to insure that men suffering from mental and nervous disorders resulting from combat are not returned to civil life until they have been given every possible treatment and regained their psychological balance."

MICHIGAN HOSPITAL SERVES RELEASED PRISONERS OF WAR

Allied prisoners of war, escapees from Japanese prison camps and American pilots who crashed on the Japanese island of Hainan were located and cared for by Army recovery teams, and portable hospitals set up for the purpose, according to a recent announcement by the War Department.

Many of the prisoners, who escaped from the Japanese and hid in the hills or were taken in by friendly Chinese inhabitants, were still unaware that the war was over, and it was the job of these recovery teams to find them and evacuate them from the island.

The 42nd Portable Surgical Hospital, headed by Captain Gordon B. Carver, Ann Arbor, Michigan, was set up in hospitals made available by the Japanese surrender, and Dutch, Australian and Indian liberated prisoners began pouring into the hospitals. Of 30,000 Chinese coolies pressed into service on the island by the Japanese, only 5,000 remained alive. They were all suffering from malnutrition, and many of them had beriberi, amoebic dysentery, and other diseases. Of the 700 prisoners evacuated from Hsiao-ling prison camp, more than half needed medical attention and 250 required hospitalization.

Through the efforts of the hospital personnel and the co-operation of the Chinese villagers, the last of the patients were evacuated on hospital ships by the early part of September. The 42nd Portable Surgical Hospital is still operating on the island, taking care of personnel located in that area.

Sixty-three per cent of the wounds received in World War II were those of the upper and lower extremities, with the lower extremities the heaviest proportion, according to Major General Norman T. Kirk, Surgeon General of the Army, who spoke recently before the Milwaukee Association of Commerce.

"There were 207,754 men of the United States Army killed in action and 571,490 wounded," General Kirk stated. "Of those wounded, 363,322 returned to duty after hospitalization and 25,145 died. These figures indicate that the rate of those wounded who died was nearly twice as great in World War I."

Of the 15,000 amputees of World War II, 14,000 needed artificial limbs, 7,000 of whom still remain in general hospitals. The balance either returned to civilian life or remained on duty as instructors for other ampu-

(Continued on Page 1320)

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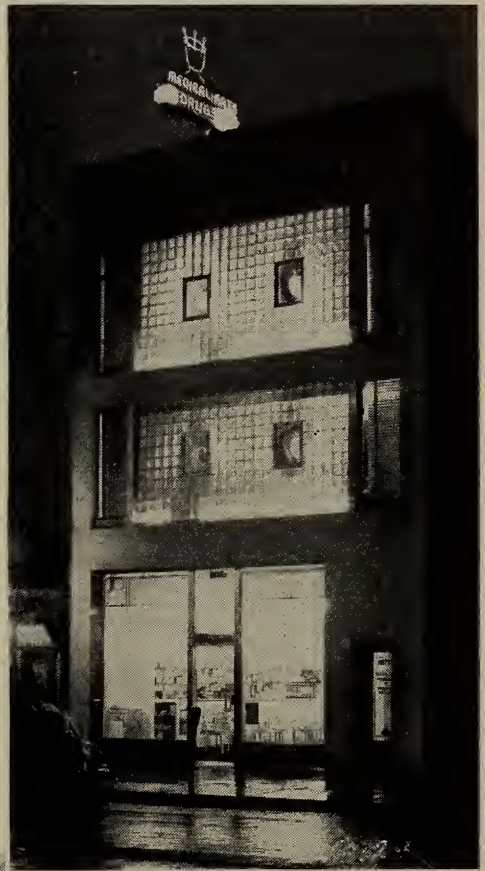
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DECEMBER, 1945

Say you saw it in the Journal of the Michigan State Medical Society

1319

MICHIGAN HOSPITAL SERVES RELEASED PRISONERS OF WAR

(Continued from Page 1318)

tees, the General continued. There have been two quadruple amputations and nine triple amputations recorded in World War II. Of the 14,000 needing prostheses, 95 per cent have lost one arm or leg, and 5 per cent have suffered two major amputations.

MEDICAL STUDENTS TO DOFF UNIFORMS

The training of naval medical students at the Wayne University College of Medicine will end on December 22, 1945, it was announced recently.

Trainees who are enrolled in the College at that time will be placed on inactive duty and permitted to continue their medical education as civilians.

University officials have also received notice from the commanding general of the Sixth Service Command that no additional Army trainees will be sent to the College of Medicine after November 1. Students now enrolled as Army trainees, it is understood, will be allowed to complete their courses.

ARMY MEDICAL DEPARTMENT GETS 6 PER CENT OF WORLD WAR II DECORATIONS

Of the 1,400,409 decorations given in World War II in recognition of meritorious service and gallantry, 6 per cent were received by Medical Department personnel, according to a biennial report by General George C. Marshall. These figures are exclusive of the Air Medal and the Purple Heart.

SULFONAMIDES AND PENICILLIN IN WAR

"Bold and successful use of sulfonamides and penicillin reduced the fatality rate of meningitis from 38 per cent in the first World War to 3 per cent in 1944, pneumonia from 24 per cent to 0.7 per cent, dysentery from 1.5 to only one recorded death. Deaths from malaria have dropped to an astounding low. In 1917-1919 there were 0.2 deaths per hundred cases . . . today the number is 0.06 per hundred.

"Great advances were made in the fiscal year in the uses of whole blood and penicillin. In North Africa the Army doctors discovered that blood plasma, although it did have a remarkably beneficial effect, could not substitute for whole blood in cases of the most severe shock. Blood banks set up in the United States sent 206,000 pints of whole blood to overseas theaters in nine months.

"The results are apparent in the lowest mortality rate in the history of any army in the world . . . 4.3 per cent of the wounded.

ARMY PERSONNEL RECEIVE INFLUENZA INOCULATIONS

All Army personnel have been ordered inoculated during the months of October and November with a new influenza vaccine as a preventive measure against influenza epidemics, the Office of The Surgeon General has announced.

The vaccine, made by injecting influenza virus into chick embryo, is to be administered in a single injection. Experimentation with the new vaccine was started early in 1943, but sufficient quantities for mass inoculation were not made available until the present year.

The University of Michigan Medical School

offers the following postgraduate course in Internal Medicine through the Department of Postgraduate Medicine:

Clinical Applications of the Basic Sciences . . . January and February, 1946.

The lecture periods will be devoted to:

Biochemistry	42 hours
Physiology	36 hours
Pharmacology	25 hours
Psychiatry	12 hours
Neurology	6 hours
Bacteriology and Immunology	24 hours
Pathology	24 hours

Teaching will be conducted by the preclinical faculty and, to a greater extent, by staff members from the clinical departments. The various aspects of the fundamental sciences which have immediate bearing upon the practice of medicine will be emphasized.

Each week five hours will be devoted to demonstrations and exercises in laboratory methods of diagnosis, with particular attention to hematology.

Physicians enrolled will attend medical ward rounds each afternoon as well as the regular weekly staff seminars and clinics of the various clinical departments.

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POSTGRADUATE COURSES AT WAYNE UNIVERSITY

The following courses are available in the Continuation Curriculum at Wayne University College of Medicine during the quarter beginning December 31, 1945. These courses are designed for practicing physicians and veterans in Detroit hospitals approved for residency training by the Committee on Medical Education and Hospitals of the American Medical Association.

Title of Course	Place	Time	Fee
Anatomy			
Advanced Dissection	College of Medicine	Arranged	\$20
Evolution of Human Body	College of Medicine	T.Th. 4-5	10
Advanced Histology	College of Medicine	T.Th. 1-4	20
Endocrinology of Reproductive Glands	College of Medicine	T.Th. 11-12	10
Problems in Neurology	College of Medicine	Arranged	
Pharmacology			
Physical Medicine	College of Medicine	Th. 1-5	10
Seminar in Pharmacology	College of Medicine	M. 3:45-4:45	5
Bacteriology			
Clinical Pathology	College of Medicine	M.W.F. 1-5 through March	10
Immunology and Virology	College of Medicine	F. 1-5 through March	10
Physiological Chemistry			
Nutrition	College of Medicine	M.Th.S. 11-12 through March	10
Carbohydrate Metabolism	College of Medicine	F. 4-5 through March	5
Seminar in Physiological Chemistry	College of Medicine	W. 4-5	5
Pathology			
Pathology of Tuberculosis	College of Medicine	Arranged	20
Pathology of Neoplasms	College of Medicine	Arranged	20
Pathology of the Heart	College of Medicine	F. 1:30-4:30	20
Internal Medicine			
Medical Pathological Conference	Receiving Hospital	F. 11-12	5
Diagnostic Conference	Receiving Hospital	S. 11-12	5
Electrocardiography	Receiving Hospital	W. 2-3 through March	10
Therapeutic Conference	Receiving Hospital	2, 4, 5 weeks Th. 11-12	5
Hematologic Conference	Receiving Hospital	1, 3 weeks Th. 11-12	5
Gastroenterology Clinic	Receiving Hospital	W. 1-2	5
Medical X-ray Conference	Receiving Hospital	T. 11-12	5
Diagnostic Conference	Wayne County General Hospital	W. 4-5	5
Seminar in Internal Medicine	Wayne County General Hospital	T. 4-5	5
Medical Pathological Conference	Wayne County General Hospital	Th. 11-12	5
Electrocardiography	Wayne County General Hospital	F. 11-12 through March	5
Medical X-ray Conference	Wayne County General Hospital	F. 1-2	5
Neurological Conference	Wayne County General Hospital	T. 10-12	5
Neurological Conference	Receiving Hospital	S. 10-12	5
Psychosomatic Clinic	Receiving Hospital	M. 2-4	5
Dermatology			
Dermopathology: (a) Inflammatory Diseases of the Skin (b) Neoplasms of the Skin	College of Medicine	T. 7-9	25
Conference on Venereal Diseases	Receiving Hospital	Th. 3-4:30	10
Seminar in Dermatology	Receiving Hospital	W. 10-11:30	10

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Continuous Caudal Analgesia

By R. V. August, M.D.

Muskegon Heights, Michigan

CONTINUOUS caudal analgesia had its beginnings with Cathelin's pioneer work in 1901. Lemmon first reported continuous spinal anesthesia in 1940. Edwards and Hingson combined these two methods and so were the first to report the use of continuous caudal analgesia in obstetrics in 1942. Several modifications by Manalan, Adams-

form of analgesia. Contraindications to this method were kept in mind. Patients were questioned about previous contact with cocaine-like drugs. Analgesia was attempted in a number of cases at the patient's request despite anticipation of a very rapid termination to labor.

We used 1.5 per cent metycaine first in normal saline solution, later in solution of three chlorides (Lilly). We used the method first described by Hingson and Edwards, consisting of the malleable needle and intermittent injections with the closed system (Becton-Dickinson). The caudal area was thoroughly scrubbed with soap and water, then painted with colored tincture of merthiolate. The patient then changed from the left lateral to the knee-chest position. The point of entry for the caudal needle was infiltrated with 1.5 per cent metycaine through a No. 25 hypodermic needle. The malleable needle was placed in the caudal canal. In the absence of a flow of spinal fluid or blood, 8 c.c. of metycaine was injected through an adaptor which was left free for a possible return flow. The patient was allowed to resume the left lateral position. After a lapse of eight to ten minutes, and in the absence of return flow, and with the patient moving her toes freely, we injected 20 to 22 c.c. of metycaine solution. Subsequent injections were made at from fifteen to sixty-minute intervals as guided by the skin level of analgesia. We found the best index to proper placement of the needle to be a warming of the feet. Other indices have been adequately discussed elsewhere.

The accompanying chart shows fifty cases that received complete analgesia. This conclusion was based on complete symptomatic relief from the time analgesia was first established through the period of expulsion of the placenta. Two cases were classified as receiving moderate analgesia.

DATES
OF
SURVEY
6-1-43/
11-20-44

NUMBER of CONSECUTIVE CASES
CONTINUOUS CAUDAL ANALGESIA
ATTEMPTED AT
MERCY and HACKLEY HOSPITALS
MUSKEGON, MICH.
59

Lundy and Seldon, Block and others, and by Siever have since been reported.

This paper presents a statistical analysis of the continuous caudal analgesia in obstetrics practiced by the author between June 1, 1943, and October 20, 1944. Sixty cases* were attempted. This represents approximately 25 per cent of the author's obstetrical practice during this period. The author attended each case himself from onset to completion. There were no assistants other than the regular hospital nurses who had no previous training with this method of analgesia. Cases were selected from the author's private practice whenever the patient expressed her desire for this

*The author administered continuous caudal analgesia to his sister, a gravida one, at Saginaw General Hospital, Saginaw, Michigan, in May, 1944. The procedure continued over six hours with complete analgesia, terminating with satisfactory delivery.

We wish to acknowledge the fine help generously given in final preparation of this paper, by Dr. Norman F. Miller of Ann Arbor, Michigan.

CONTINUOUS CAUDAL ANALGESIA—AUGUST

TABLE I.

No.	Hosp. No.	Pt.	Age	Grav	Date	Infant wt.	Sex	Labor Prior to Caudal			Caudal		Blood Pressure			Delivery		Blood Analgesia	
								Onset—Gest.†	Time	R	Time	c.c. 1½% Metycaine	Office	Hosp.	Min.	Max. Drop	Position	Epis. Forceps	Loss Comp. Min. to Comp.
1	H13712	GL	26	iii	6-4-43	6-8	M	I	1:28	Second Grs. 1½	3:47	110	130/90	130/100	118/90	12/10	OLA	ML	50 C 21
2	B3092	CM	28	ii	6-15-43	7-12½	M	S	3:40		2:20	90	120/80	102/64	92/48	10/16	OLA		25 C 10
3	B3180	DM	30	iv	6-19-43	7-4	F	S	4:30		6:34	210	130/90	120/90	110/80	10/10	OLA	FLAC	75 C 10
4	B3205	SG	33	iii	6-20-43	8-1	F	I	1:00		2:40	80	110/70	108/70	100/66	8/4	ORA	LML	50 C 15
5	B3786	AS	21	ii	7-18-43	7-½	F	S	3:14		1:08	45	128/78	128/78	120/70	8/8	ORA		75 C 21
6	B4027	VR	23	iii	7-28-43	7-3	F	I	2:42		2:52	90	112/78	112/78	100/70	12/8	Double Footling	FLAC	25 C 15
7	B4366	MG	23	i	8-14-43	6-9	M	S	7:58		3:09	80	122/90	122/90	120/70	2/20	ORA	LML LOW	25 C 15
8	B4462	MC	30	iii	8-18-43	6-8½	M	S	4:58		2:29	70	136/84	122/80	118/78	4/2	OLA	ML	50 C 51
9	B4741	HO	32	ii	8-28-43	7-5½	M	S	2:42		2:22	120	118/80	118/80	80/42	38/38	ScRA to OA Manually	LML LOW	25 C 96
10	B5113	SB	21	i	9-15-43	6-2½	M	S	6:00	Second Grs. 1½	5:00	122	130/92	130/70	130/70	0/0	OLA	ML LOW	100 C 21
11	B5896	AH	25	i	10-30-43	8-2	M	S	29:30	Second Grs. 3 Numbutal Grs. 1½	3:40	70	106/80	106/82	100/70	6/12	OLA	LOW	25 C 15
12	H7052	DL	31	iv	11-8-43	6-2½	M	I	12:00		2:58	95	170/122	185/100	154/94	31/6	ORA	LML	25 C 23
13	B6339	EJ	25	i	11-25-43	8-4	M	S	17:38	Second Grs. 4½	2:14	70	108/83	116/78	84/62	32/16	OLA	LOW	100 C 17
14	B6531	JF	22	iii	12-6-43	7-7½	M	S	4:21		1:59	83	120/68	100/70	80/40	20/30	OLA	FLAC	25 C 06
15	B6804	MM	36	iii	12-25-43	6-9½	M	I	1:04		1:38	105	134/80	120/90	126/72	+6/18	OLA Breech		100 C 60
16	C86	KH	30	i	1-6-44	6	M	S	1:55		2:47	82	134/86	110/70	100/60	10/10	OLA	ML	50 C 10
17	H15805	AD	32	i	1-17-44	8-5½	F	S	11:45	Second Grs. 1½	4:50	130	120/74	112/70	102/70	10/0	OLA	LML ML LOW	25 C 45
18	H15839	EG	31	i	1-21-44	7-7½	M	S	18:25	Second Grs. 4½	4:25	107	122/84	112/78	110/78	2/0	ORA	ML LOW	25 C 35
19	H1499	RL	31	ii	1-23-44	7-12½	F	I	3:55		6:00	164	116/84	90/60	100/64	+10/+4	Frank Breech		100 C 10
20	H15881	AC	27	v	1-26-44	7-5	F	I	2:10	Numbutal Grs. 1½	1:08	30	144/86	138/72	122/72	16/0	OLA		25 C 23
21	H5928	MR	31	iii	2-14-44	8-9¼	M	S	4:35		2:50	95	94/54	95/54	68/36	27/18	ORA	LML LOW	25 C 25
22	H16093	KN	19	i	2-18-44	6-7¼	F	S	4:15		1:50	118	114/80	130/84	118/50	12/26	OLA	LML	50 C 20
23	H16169	IP	25	ii	2-26-44	7-13¼	F	S	4:52		1:18	73	136/98	140/80	138/70	2/10	OLA		25 C 23
24	H16277	AB	19	i	3-9-44	8	F	S	3:10		2:27	123	130/90	138/80	108/68	30/12	OLA	LML	25 C 35
25	H16278	EG	24	iii	3-9-44	6-1¾	F	I	3:15		1:15	65	130/80	130/80	130/80	0/0	ORA		50 C 35
26	C997	LL	24	ii	3-15-44	5-7½	F	S	8:00	Second Grs. 3	0:38	73	100/68	137/74	118/72	19/2	ORA		125 C 15
27	H16486	LL	31	i	3-30-44	7-¼	F	S	3:35	Numbutal Grs. 3	5:15	203	128/70	120/70	98/56	22/15	OLP to OLA Manually	LML LOW	75 C 40
28	H12481	DF	21	ii	4-15-44	5-6¼	F	I	4:15	Second Grs. 1½	2:12	103	148/108	152/112	120/76	32/36	OLA	ML LOW	25 C 40

CONTINUOUS CAUDAL ANALGESIA—AUGUST

20	C1377	PM	23	iii	4-10-44	7-4	M	S	T	8:00		1:55	75	0.7	152/80	122/80	112/72	10/8	OLA	50	C	14	
30	H16691	MB	25	i	4-21-44	7-15	M	S	T	5:23	Nembutal Grs. 1½	4:40	203	1.0	12/80	136/70	96/60	46/10	ORA	LML	25	C	27
31	C1529	PT	22	iii	4-30-44	7-14	F	S	T	3:26	Nembutal Grs. 1½	5:39	180	0.5	122/80	110/70	100/60	10/10	OLA	ML	50	C	19
32	H16813	RP	31	v	5-23-44	8-8	F	S	T	8:34		0:36	51	1.4	122/70	130/70	128/64	2/6	OLA		25	C	22
33	C2296	JD	30	i	7-1-44	6-11	F	I	T	13:00	Nembutal Grs. 3	1:00	40	0.6	114/80	120/100	110/88	10/12	OLA	LML	100	C	15
34	C2944	DB	22	i	7-5-44	7-5	F	I	T	4:34	Secomol Grs. 1½	1:41	60	0.6	142/90	120/90	110/80	10/10	OLA	LML	75	C	12
35	H7418	IB	30	viii	7-6-44	8	F	S	T	3:30		1:21	80	1.0	144/74	124/64	120/0	4/-64	ORP		50	C	25
36	C2509	AC	20	iii	7-16-44	7-8½	F	S	T	4:13		0:55	80	1.5	122/80	118/90	110/80	8/10	ORA		75	C	18
37	H17616	LS	35	iv	7-21-44	7-14½	F	S	T	4:30	Secomol Grs. 1½	1:40	60	0.6	160/100	160/100	138/82	22/18	OLA	ML	25	C	20
38	H9339	JH	26	ii	7-29-44	7-14½	M	S	T	3:45	Nembutal Grs. 3	0:35	40	1.1	110/80	140/74	110/68	36/6	ORP to OA Manually	ML	25	C	09
39	H17708	EN	32	iv	7-29-44	7-10	F	I	T	4:50		1:12	40	0.55	122/80	122/80	120/70	2/10	ORA		25	C	10
40	H6648	EP	29	iii	8-4-44	8-14½	M	S	T	2:15		3:54	100	0.4	120/70	130/78	124/100	6/+22	OLA		50	C	07
41	H17850	LC	25	iii	8-13-44	6-8	M	I	*	9:50	Nembutal Grs. 1½	7:50	129	0.27	110/70	140/88	110/70	30/10	SLA to Breach Manually		75	C	12
42	C2636	HP	22	i	8-15-44	9-7	M	S	T	16:38	Secomol Grs. 4½ Nembutal Grs. 1½	2:42	95	0.59	122/70	120/84	98/60	22/34	POP to OA Manually	ML	50	C	20
43	C2956	MG	30	i	8-16-44	7-10	M	S	T	4:00		6:40	210	0.5	120/80	128/94	118/88	10/6	OLP to OLA Manually	LML	50	C	14
44	C2959	FR	28	ii	8-17-44	5-½	M	S	T	10:07		0:58	35	0.6	106/80	100/80	98/68	8/12	OLA		25	C	20
45	C3545	MC	21	i	10-8-44	7-¾	F	S	T	1:43	Nembutal Grs. 3	2:37	125	0.8	134/80	140/80	110/70	30/18	Trans. to OLA Manually		25	C	32
46	C3624	BL	26	i	10-14-44	6-2	F	S	T	1:51		2:26	85	0.6	128/102	130/70	110/60	20/10	OLA		25	C	20
47	H18603	ST	18	i	10-26-44	4	M	S	S	4:55	Morphine Gr. ¼ Atropine Gr. 1/160	1:35	54	0.57	125/70	122/86	98/60	32/26	OLA	ML	25	C	18
48	C3806	NH	19	iii	10-28-44	6-5½	F	S	T	5:04		1:54	87	0.77	128/80	120/84	114/84	6/0	ORA		40	C	08
49	H18822	EC	29	i	11-15-44	8-5½	M	I	T	3:00		1:00	53	0.9	140/90	120/68	110/60	10/8	OLA		25	C	18
50	C4071	JL	28	iv	11-20-44	7-3½	M	I	T	3:02	Secomol Grs. 1½	1:30	73	0.8	124/80	120/70	110/68	10/2	OLA	LML	100	C	12
51	B4553	VV	21	i	8-21-43	8-1½	F	S	T	10:45		4:50	150	0.5	120/60	120/60	108/60	12/10	OLA	LML	125	Mod.	30
52	C204	VP	23	i	1-14-44	6-11	M	S	T	15:30		5:05	180	0.6	134/94	98/64	98/40	0/24	OLA	LML	200	Mod.,	30
1	H13691	MO	29	iv	6-1-43	8-12½	F	S	T	2:07	Secomol Grs. 1½	0:26	30	1.15	138/92	150/100	150/90	0/10	OLA		200	Inc.	
2	B3039	JM	27	iii	6-13-43	6-½	F	I	T	3:20		7:00	170		112/68	112/68	110/60	2/8	OLA	LOW	200		
3	B3151	WG	21	iii	6-17-43	5-8	F	S	T	2:30		0:30	30		120/80	120/80			OLA		250		
4	B4215	KT	24	i	8-7-43	6-15	M	S	T	9:27	Secomol Grs. 3	3:28	120		132/90	130/80	108/66	22/14	OLA	LML	300		
5	B4712	KA	27	iii	8-17-43	5-14½	F	I	T	0:45		0:05	10		124/70				OLA		200		
6	B6116	RO	25	i	11-10-43	7	F	I	T	9:25					120/74	120/74			ORA	ML	200		
7	C569	VT	20	i	2-10-44	6-8	F	I	T	7:37	Secomol Grs. 3	0:58	129		120/90	100/70	104/60	+4/10	OLA	ML	175		

†Spontaneous = S; term = T; induced = I *8½ mos.; † 8 mos.; § 7 mos.

They were free of all pain except for the last few contractions with the fetal head on the perineum. A few whiffs of ether were allowed these two patients, to their complete satisfaction. Adding the one case with insufficient data available (see footnote) fifty-three cases or 88 per cent of the sixty received adequate analgesia.

ANALGESIA		
INADEQUATE	MODERATE	COMPLETE
7	2	50

TOTAL	INADEQUATE ANALGESIA	SEVEN
1. LOW LYING DURA	3 TIME INADEQUATE FOR INDUCTION	1 PT. HIGHLY NEUROTIC
1 PATENT SACRAL FORAMINA	1 PT MOVED TERMINALLY, NEEDLE OUT NOT REPLACED	

Seven patients failed to receive adequate analgesia. One patient was shown by subsequent x-ray examination to have patent sacral foramina. These did not allow for a concentration of local anesthetic sufficient for an adequate level of anesthesia. One was a highly nervous and excitable girl who maintained that relief was inadequate in spite of a skin analgesia level bilaterally that extended up to the seventh rib. One patient received adequate analgesia for more than six and one-half hours. Labor progressed satisfactorily during this time. Then the needle slipped out. It was not replaced because the patient was ready to deliver by the time this was noticed. The fourth patient had a low lying dura which was penetrated with a 2.5-inch needle. Spinal fluid flowed freely. The needle was immediately withdrawn. The other three patients were injected despite the imminence of delivery and all required inhalation anesthesia because time was insufficient for production of caudal block. We believe these seven cases were among those patients unsuited for continuous caudal analgesia. We do not believe them to be a reflection on the method.

Of the fifty-two successful cases tabulated, several were worthy of individual discussion. One set of twins¹⁵ was delivered. Three patients^{8,11,15} were overweight at 207, 230 and 241 pounds, respectively, but presented no particular difficulty to insertion of the malleable needle.

One patient⁴ had a marked deformity of her sacrococcygeum as a result of an old ice-skating accident. One primipara was delivered at seven months of gestation of a previously undiagnosed monstrosity.¹⁶ She was not told of this until after

being taken to her own room. A continuous conversation sufficed to keep her ignorant of her delivery. One patient⁴⁶ had had a "nervous breakdown" with prolonged psychiatric care several years prior to this, her first, pregnancy. She was mildly nervous prior to caudal analgesia but was a marvelous patient from that point on. Another patient⁹ continued to experience occasional cramps until the skin level of analgesia reached the level of the 4th dorsal interspace. Labor and delivery then progressed satisfactorily.

One multipara²⁹ had analgesia started when she had been in active labor two hours, when contractions were manifest every three minutes, and when the cervical dilatation was 5 cm. with a cephalic presentation. Analgesia was continued for six hours. Maximum dilatation obtained was 9 cm. and optimal station noted was plus 1 but uterine contractions ceased. Caudal block was discontinued. The patient left the hospital the following morning with a diagnosis of false labor. Seven days later she returned in active labor. Caudal analgesia was begun when the cervix was 6 cm. dilated and was continued for one hour and fifty-five minutes to a satisfactory completion.

A number of patients were not good risks. One gravida 3³¹ had lost her previous two babies at two and eight months' gestation. Her urine sugar varied from a trace to 4+ plus during the last five months of this pregnancy. She was managed with dietary measures alone but required hospitalization twice prior to confinement. The caudal delivery was uneventful. Three patients^{15,22,42} manifested varying degrees of albuminuria throughout pregnancy. Three others^{28,35,37} were definitely pre-eclamptic. Two patients^{13,40} had very severe attacks of bronchitis at the time of confinement, one not being able to speak in tones above a whisper and having a temperature of 101 degrees F. orally. One patient¹⁹ was a very good risk but needed a perineorrhaphy and hemorrhoidectomy. These were done under the same continuous caudal analgesia immediately following delivery.

One patient²¹ complained of a severe headache in association with a marked blood pressure drop. Ephedrine sulfate grain $\frac{3}{8}$ was administered intramuscularly with satisfactory results. One patient²⁷ vomited once shortly after administration of 22 c.c. of metycaine. Two patients^{16,18} complained of faintness and dizziness. These symptoms were probably associated with too rapid injection of metycaine, because they appeared shortly after

the first 22 c.c. dose, were present for a few minutes, and were absent during the remainder of the two hours and forty-seven minutes and four hours and twenty-five minutes labors, respectively.

The fifty-two cases having satisfactory analgesia were analyzed statistically. Twenty-one were primigravida, thirty-one multigravida.

GRAVID	
I	21
II	9
III	14
IV	5
V	2
VII	1

ONSET of LABOR			
PREMATURE	TERM	SPONTANEOUS	INDUCED
5	47	37	15

Labor began spontaneously in thirty-seven. It was induced in fifteen. It began prematurely in five, and at term in forty-seven. The average age of the mother was 26.4 years. The average infant weight was 7.2 pounds.

PRE-CAUDAL BARBITURATE SEDATION	
WITH	WITHOUT
20	32

Twenty patients received precaudal sedation with barbiturates (seconal or nembutal). Thirty-two received none. The average time elapsed between the onset of the first labor pains, with the patient still at home, and the first caudal injection in the hospital was six hours and twenty minutes. The average patient enjoyed two hours and forty-eight minutes of continuous caudal analgesia. Twenty-two and eight-tenths minutes was the average amount of time elapsing between the injection of the test dose and the patient's statement that she no longer felt pain during a contraction. The average number of cubic centimeters of mety-caine received by our patients was 98. This averaged 0.69 c.c. per minute for the entire period of time.

For purposes of comparison we read and recorded each patient's blood pressure at different times. These readings were taken at the last antenatal examination in our office, just prior to beginning caudal analgesia, and the lowest of several readings taken during continuous caudal analgesia. The accompanying chart shows no significant trend

in blood pressure changes between the first two instances. It does show a drop in systolic pressure (forty-seven cases) averaging 14.6 mm. of mercury and just as significant a drop in diastolic pressure (forty-four cases) averaging 13.2 mm. of mercury.

BLOOD PRESSURES												
	LAST GESTATION / FIRST LABOR						DURING CAUDAL					
	RISE			DROP			RISE			DROP		
	NO	MAX	AV	NO	MAX	AV	NO	MAX	AV	NO	MAX	AV
SYSTOLIC	17	37	13.35	23	36	14.0	2	10	8	47	46	14.6
DIASTOLIC	15	20	9.4	20	32	14.55	2	22	13	44	64	13.2

DELIVERY									
EPISTOMY		1 st LAC		POSITION			FORCEPS		
✓	5	✓	5	OA	OP	BREECH	OTHER	✓	5
27	25	3	49	42	5	3	3	16	36

Delivery was facilitated with an episiotomy in twenty-seven patients. Three suffered a first degree laceration. Forceps were applied in sixteen deliveries. Eleven of these were primigravida. Five more were multigravida. Ten primigravida delivered without forceps, infants weighing from 4 to 8 pounds 5.5 ounces and averaging 6 pounds 10 ounces. Thirty-six were delivered spontaneously. Position of the baby was occiput anterior in forty-two, occiput posterior in five, breech in three, scapula right anterior in one, sacrum left anterior in one, and a transverse in one.

	MAX.	MIN.	MEAN	AV.
AGE	36	18	27	26.4
INFANT WEIGHT	97	4	685	72
PRECAUDAL TIME	2930	100	1515	6.20
NO. MINUTES BETWEEN FIRST INJECTION & COMPLETE ANALGESIA	96	6	51	22.8
CAUDAL TIME	750	0.35	412	2.48
CC. 1% METYCAINE	210	30	120	98
CC. METYCAINE PER MIN.	2	0.3	1.15	0.69
APPROX CC. BLOOD LOSS	200	25	112.5	48.3
	300	125	162.5	162.5
	300	175	232.5	217.8

For purposes of comparison, it was assumed that our average obstetrical patient receiving inhalation anesthesia lost 200 to 300 c.c. of blood. We then estimated as nearly as possible the blood loss with each delivery. No attempt to measure was made.

The accompanying chart shows an average blood loss of 48.3 c.c. for the patients who had complete analgesia, 162.5 c.c. for those classed as having moderate analgesia and 217.8 c.c. for those classed as having inadequate analgesia. The exact figures were estimated, the trend was definite.

We believe the indications for continuous caudal analgesia to be: (1) poor risk mothers, (2) prematurity, (3) abnormal positions, (4) desirability of comfort during labor.

We believe the advantages to be: (1) maternal and infant physiology undisturbed, (2) relief of pain in the presence of complete consciousness, (3) safer than many other methods of analgesia and anesthesia, (4) length of labor usually reduced, (5) difficult positions often facilitated, (6) no post-anesthetic sequelae, (7) less blood loss in third stage, (8) no interference with uterine contractions.

We believe the contraindications to be: (1) caudal area dermatitis, (2) gross deformity or disease of the spine or central nervous system, (3) extremely nervous or apprehensive patients, (4) unengaged fetal head, (5) disproportion between fetus and maternal pelvis, and gross deformities of the pelvis, (6) anemia, (7) placenta praevia or abruptio placenta, (8) anticipation of a short easy labor, (9) sensitivity to the drug, (10) obesity (we believe obesity to be an added obstacle rather than a contraindication).

We believe the disadvantages to be: (1) newness of the method with the possible added complications yet to be discovered, (2) more frequent abnormal positions, (3) more frequent use of forceps, (4) time consuming for attendant.

Summary

1. Of sixty consecutive attempts to obtain adequate continuous caudal analgesia in obstetrics, seven were failures. None was chargeable to the method. It was demonstrated that this method is not applicable to every patient.

2. The seven failures to obtain adequate analgesia were as follows: (a) one patient with a low lying dura, (b) one patient with patent sacral foramina, (c) one patient who was highly nervous and excitable, (d) one patient who obtained adequate analgesia for over six hours, but had this method discontinued when the needle slipped out, (e) three patients who had continuous caudal analgesia started too late in labor. These instances

exemplify some of the contraindications to continuous caudal analgesia.

3. Several poor risks were managed satisfactorily with this method. These were patients with glycosuria, albuminuria, and with severe bronchitis.

4. Untoward reactions were: (a) severe headache associated with blood pressure drop, (b) vomiting, (c) faintness and dizziness.

5. The patients receiving pre-caudal barbiturates may possibly have enjoyed a smoother course although this was not definitely discernible.

6. No definite trend in blood pressure changes was noted until continuous caudal analgesia was instituted. Then the tendency was downward.

7. Eleven primigravida were delivered with forceps, ten without. This percentage of forceps deliveries is higher than our average in non-caudal deliveries.

8. The position was other than OA in eleven. This percentage is higher than that in our non-caudal deliveries.

9. There was a definite decrease in the amount of blood lost during the third stage of our continuous caudal patients.

10. The patients receiving adequate continuous caudal analgesia were thoroughly satisfied. The author administering it alone in every case found himself well compensated for the considerable infringement on his time by the thanks of happy patients.

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Experiences with Fibrin Fixation

Methods of Skin Grafting

A Clinical Evaluation

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THE ART of skin grafting is at present enjoying a position in the forefront of medical activity never before accorded it. We are completing a decade of widespread interest in the early and late care of burns. The gospel has been spread that early coverage of areas, denuded of skin

by burns, is a *sine qua non* for lowered mortality and early return of function. This has demanded more extensive knowledge of the techniques of skin transplantation.

We are now at the end of a second World War. In response to the great demand for care and rehabilitation of the wounded, great centers have arisen. The work done promises an impetus to the progress of plastic surgery which may exceed even the remarkable experiences of World War I. Already a myriad of reports on every phase of skin transplantation have been published. During the past year there have appeared for the first time books^{1,6} devoted exclusively to the subject.

The methods of grafting now in general use had their origin largely in the nineteenth century and have been developed to their present state of efficiency by the great masters of the craft. These methods are good and have stood the test of time. Three types of grafts are commonly used. These are: (1) the small deep graft (J. S. Davis) often improperly called "pinch grafts" after an obsolete method of cutting them, (2) the split graft (V. P. Blair and J. B. Brown) which is a development of the older razor grafts, (3) the full thickness graft (Wolfe Krause). Other names commonly employed, such as "dermatome graft" (E. C. Padgett⁵) or "film cemented graft" (J. P. Webster¹³) refer to modifications in the method of procuring or handling the split thickness graft.

Modern methods have resulted in a remarkably high percentage of success in the application of the standard grafts. It is reasonable to expect satisfactory take in 90 per cent of small deep and split grafts and 80 per cent of full thickness grafts. Certain tried principles must be adhered to, if these results are to be obtained. Most important of these are cleanliness of the recipient area, hemostasis, anchorage of the graft and the maintenance of adequate pressure for a period of at least one week. These excellent results can be obtained by any surgeon who is willing to take the time and trouble to apply the principles. The great obstacle to everyday use of the most common graft, the split graft, has been the necessity of long practice, in order to cut satisfactory grafts consistently by the free hand method. This has been overcome by the introduction of Padgett's dermatome, the use of which is learned quickly; and more recently, the Caltagirone² knife, which employs dermatome principles.

Any new departure in the application of skin grafts must prove its worth as an improvement over existing methods, and the present study was undertaken to make this comparison.

Fibrin Fixation Methods

Fibrin fixation is based on the well-known phenomenon of blood coagulation. Blood or blood plasma clots when its contained fibrinogen is exposed to the action of thrombin.⁴ *In vivo* this thrombin is derived from prothrombin when the latter is acted upon by thrombokinase in the presence of calcium. The clot adheres to living tissue and in the natural repair of wounds is used by the body as a skeleton which is later invaded by granulation tissue in the process of healing. *In vitro* blood plasma is coagulated by exposure to any solution containing thrombin.⁴ Employing this principle, work has been done on fibrin fixation of nerve suture sites¹¹ in addition to the experimentation with skin grafts.

In fibrin fixation methods, the skin graft is adhered to its recipient bed, using coagulated blood plasma as a glue. Rapid coagulation in a matter of seconds is produced by exposing the graft, wet with plasma, to a solution containing thrombin. Different investigators have developed different methods of preparing the solution of thrombin. Tidrick and Warner¹² employ a method developed in their laboratory in which the thrombin is prepared from beef plasma. This has been pro-

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duced in quantity by one of the biological companies, as a sterile powder under the name of *Thrombin Topical*.^{*} In their technique, the donor skin is saturated with human plasma. Either fresh homologous or autologous citrated plasma was found to be satisfactory. The recipient bed is flooded with an aqueous or normal saline solution of thrombin topical and the graft immediately set in place.

Working independently, Sano^{7,8} developed a method of fibrin fixation which she calls "coagulum contact." In this method, the plasma and thrombin solution are prepared as needed from a small sample of the patient's own blood. The blood is heparinized and centrifuged. The plasma is pipetted off and saved. To the remaining cells, Tyrodes solution is added and the mixture centrifuged. The resulting supernatant fluid is removed with a pipette and is known as cell extract. This contains the thrombin.

In fixing the skin graft, cell extract is painted on the raw surface of the graft and blood plasma on the recipient bed, using camel's hair brushes. The graft is then tamped down in place.

In both techniques the traditional pressure dressing is entirely eliminated. Often the graft is not anchored with sutures. In forty-eight hours, grafts take on a purplish color and are obviously attached as living tissue.

In clinical trial, Sheehan¹⁰ employed the Sano technique and reports favorably. Young and Favata¹⁴ have reviewed in detail the methods of preparing materials for fixation. Employing thrombin topical with the technique of Tidrick and Warner, they have achieved encouraging results. They consider the Sano preparation more cumbersome and hence prefer thrombin topical. It was the writer's experience that the Sano plasma and cell extract could be prepared in the laboratory in any desired quantity in about thirty minutes. Recently, Sano has taken steps to improve and simplify the preparation of cell extract.⁹

To compare the efficacy of grafting by these methods with traditional technique, a series of cases was selected. An attempt was made to secure examples of skin grafts of the common types, particularly in situations known to present difficulties. Hence were chosen grafts in the interdigital webs, about the mouth and on the eyelids be-

cause these offer difficulty in fixation. An aged individual with an infected granulating area was included as a severe test. In all cases the techniques of Tidrick and Warner and Sano were followed exactly and without modification.

Report of Cases

Case 1.—P. B., a negro woman, aged forty-four, had a radical mastectomy October 26, 1943, for advanced carcinoma of the right breast. Wide excision resulted in a raw area 20 cm. by 8 cm. over the anterior surface of the chest which was not covered at the time of operation. The periosteum of the ribs and intercostal muscles were exposed. After three weeks, a thin layer of granulations had covered the area. After three days of preparation with normal saline wet dressings and dusting with sulfathiazole powder, the area was grafted as follows:

It was subdivided into three approximately equal rectangles. Small deep grafts from the right thigh were placed on rectangle one, a free hand split thickness graft from the right thigh on rectangle two and a full thickness graft (Wolfe) dissected from the abdominal wall and applied to rectangle three. All grafts were applied by fibrin fixation, using the "coagulum contact" method of Sano. A few small deep grafts were tamped down without coagulum as controls. A single layer of vaseline gauze was gently spread over the grafts. No pressure dressings and no sutures were used.

Inspection after forty-eight hours showed the grafts to appear healthy and viable and, when tested with forceps, adhesion to the recipient bed was firm. The control grafts were dull and lifeless and eventually sloughed. In subsequent inspections, over a period of four months, the grafts remained healthy and achieved a good coverage of the area. There was a loss of about 4 mm. around the edge of the full thickness graft which was complete in three weeks.

This case, which was largely a preliminary test, confirmed Sano's work that fibrin fixation by the coagulum contact technique would adhere grafts of all types on a granulating surface without pressure or suturing. Moreover, it demonstrated a distinct advantage in that no dressing was needed on the chest wall where adequate pressure dressings have tended to restrict respiration. The common experience of tissue maceration under pressure dressings was entirely absent.

Case 2.—R. S., a white boy, aged five, suffered a flame burn from clothing ignited by a stove. The left axilla and lateral chest wall were involved. After preparation with wet dressings of normal saline, the area presented a surface covered with exuberant granulations. These were pared down and the resultant raw surface covered with split thickness grafts from the back, cut with a Caltagirone knife. The grafts were adhered by fibrin fixation using thrombin topical after the technique of Tidrick and Warner. A light bandage of vaseline gauze and one layer of dry gauze were applied to prevent soiling. No pressure dressing was used and no suturing

^{*}Thrombin topical was prepared for experimental work by Parke, Davis & Co., who supplied the product for use in this study.

was done. The immediate and postoperative condition of the grafts was excellent.

In this case, fibrin fixation adhered the skin transplant to a fresh raw surface successfully. The absence of bulky pressure dressings was an advantage in the postoperative bedside care of a young child. It was also noted that the thrombin topical was helpful and time saving in controlling oozing from the raw area. When sprayed on the raw surface, capillary bleeding ceased in a matter of seconds.

Case 3.—B. K., a white woman, aged forty, third degree burn of scalp, face and hands resulting from gasoline explosion. Grafting of forehead: after sloughing was complete, the forehead presented a mass of granulation tissue. This was dissected out, down to the level of the frontalis. An exact cellophane pattern was made and a full thickness graft cut to pattern was dissected from the skin of the abdominal wall. The defect in the donor wall was closed by undercutting and approximation of edges. In extent, the graft reached from the preauricular area on the left side to the lateral border of the right orbit. It was set in place with plasma and thrombin topical but the margins were sutured to the surrounding tissues with interrupted dermal sutures. No pressure dressing was applied. The result was a take estimated at 70 per cent. An area 2 cm. in diameter over the glabella sloughed. Here the tenting tendency, produced as the skin crossed from one supraorbital ridge to the other, was sufficiently strong to break the fibrin adhesion. Another area 3 cm. in diameter in the left preauricular region also sloughed. This was the most dependent part of the graft and exuded serum collected here producing separation.

In this case, 70 per cent success was obtained with a full thickness graft long known to be the most precarious of grafts.

Tenting of the skin and serum collection caused partial losses. However, the percentage compares favorably with results in full thickness grafts held in place by pressure dressings. It is probable that fibrin fixation and pressure dressing combined would have resulted in 100 per cent take of this graft.

Suturing of the graft was done to achieve proper fit and optimum tension of the skin. It has been stressed by experimenters in this field, that suturing of fibrin fixed grafts is unnecessary for fixation. It is also stated that the absence of suturing makes for shorter operating time and eliminates the bleeding which is often an annoyance at this stage of attaching a skin graft by traditional methods. While this is true, it leaves out of account the other very important reason for suturing grafts, namely, the achievement of an optimum or normal tension.

Split thickness grafts, and to a greater extent, full thickness grafts, contract markedly after being removed from the donor area. Simply to tamp them into place is to sacrifice up to 50 per cent of

their coverage potentiality. Full thickness grafts, which provide the best cosmetic result of any free graft, are ordinarily cut to pattern and only by suturing can their edges be made to fit accurately the outline of the defect. Again, as the graft takes its later form on the recipient bed, unsightly wrinkling will occur if optimum tension is ignored. Anchorage with sutures is the best way to avoid such a result.

Case 4.—B. K., same patient as Case 3. Grafting of the eyelids: after application of wet dressings of normal saline, the eyelids were covered with a light film of clean granulations. Ectropion was developing rapidly. The granulations were dissected off until the fibers of the orbicularis oculi were exposed. The lids were then adhered after the manner of Wheeler. A thin split graft, cut free hand from the thigh and sufficient to cover both upper and lower lids, was tamped into place; fixation being done by the Sano technique. No sutures, no pressure dressing and no mould were used. The take was good and complete, excepting a square centimeter just medial to the inner canthus.

In this case, fibrin fixation by the Sano technique achieved a good take in a site having some movement despite the adhered lids. The square centimeter lost was in the long-known danger area at the inner canthus. Hence, the use of a mould which largely overcomes the difficulty, if it fits properly, should probably not be abandoned. It was noted at the end of two months that marked wrinkling of the graft occurred.

Case 5.—B.K., same patient as Cases 3 and 4. Grafting of left cheek and buccal margins: previously, by means of a Z plastic procedure, neck skin had been moved up on the face to decrease the size of the area needing a free graft. There remained a granulating area which covered most of the left cheek and continued past the left angle of the mouth on upper and lower lips to within a centimeter of the right angle. Granulation tissue was dissected out until subcutaneous fat was exposed. Bleeding was controlled by a spray of thrombin topical, except for small arterial bleeders which were grasped with hemostats and tied. A thick split graft was removed from the back with the Caltagirone knife and set in place over the facial defect, employing thrombin topical with the technique of Tidrick and Warner. Take was good except at the angle of the mouth and lips where a slough occurred. The state of this graft was watched closely and it was obvious after twenty-four hours that the adhesion of the graft was not holding about the mouth.

In this case, the hemostatic action of thrombin topical was very helpful during the dissection. In the postoperative period the tendency of the facial tissues, fed by their rich blood supply, to pour out serum exudate was noted as soon as the graft separated from its bed at the angle of the mouth. The patient was allowed to eat and drink in order to place a maximal strain on the adhered graft.

Case 6.—B. K., same patient as Cases 3, 4 and 5. Grafting of the dorsum of the hand: the granulating area extended from the distal interphalangeal joints of all of the fingers to the wrist joint, and included the entire dorsum of the hand. The interdigital webs were involved to the palm. The granulations were dissected out. A full thickness graft, cut to pattern, was taken from the medial surface of the right thigh and set in place by the technique of Sano. Sutures were placed at intervals about the periphery to secure an exact fit. Small sea sponge pressure dressings were placed over the first and fourth interdigital webs. The remainder of the graft was covered with vaseline grease gauze without pressure. The take was good. The second and third interdigital webs were lost through separation. The first and fourth webs survived under the pressure dressings. A serpiginous ulcer 4 cm. by 0.5 cm. in extent appeared near the border of the dorsum and eventually sloughed. The estimated final take was 90 per cent. The ultimate cosmetic and functional result was superior.

The result in this case was excellent for a full thickness graft. The absence of maceration and the comfort of the patient were noteworthy. Serpiginous ulcers do form at times in full thickness grafts, without known cause. Fibrin fixation did not hold the interdigital webs. That the two webs under pressure survived, suggests that in many cases fibrin fixation and pressure may be combined to advantage.

Case 7.—W. S., a man aged seventy-eight, suffered a flame burn when his clothing was ignited by an overturned stove. Burn was second degree on the abdomen and third degree on the left lower extremity from groin to ankle. The patient was immediately treated with vaseline gauze pressure dressings. He was incontinent of urine and feces and the burned area rapidly became infected, *B. pyocyaneus* being prominent. In the face of frequent soiling, it was felt that grafting must be attempted despite infection because evidence of debilitation was appearing. Split thickness grafts from the right thigh were placed on the left thigh and immobilized with pressure dressings of Xeroform ointment gauze, sea sponges and elastoplast bandage. Profuse discharge forced inspection of the graft after four days. This revealed almost complete loss. In addition, debility of the patient was such that after eighteen days the donor area failed to show customary epithelialization, being raw and weeping. The burned area presented only a light coating of pale infected granulations. These were treated with dressings of Dakin's solution alternating with 4 per cent acetic acid and sprinkled with sulfanilamide and sulfathiazole. After six days, the area was considered sufficiently clean for another attempt at coverage. Small deep grafts were taken from the abdomen and tamped down on the granulations, using plasma and thrombin topical for adhesion. A single layer of gauze moistened with saline was placed over the grafts. The donor areas of the small deep grafts were individually closed with silk sutures as suggested by Davis.³ Two weeks later, the patient developed bronchopneu-

monia and died. However, sufficient time elapsed after the grafting to note that the grafts adhered well and the donor areas healed by first intention.

It would be hard to imagine a problem in skin transplantation more discouraging than this. Under such circumstances, fibrin fixation seems the method of choice because treatment of the infection can be continued while grafting is in progress. It is also of note that the small deep graft was the best under these circumstances. Grossly improper use of this graft has given it undeserved disrepute. In many problems, it is the procedure of choice. In aged or debilitated individuals, suturing the individual donor sites avoids the pitfall of replacing one raw area with another.

Case 8.—B. K., same patient as Cases 3, 4, 5 and 6. Lining of flap from arm: complete destruction of the nose necessitated total rhinoplasty. Since all suitable forehead skin was lost, the anteromedial surface of the left arm was selected for a donor site. A tube pedicle was raised on the arm and a flap outlined at its lower extremity. After a delay of three weeks, the flap was dissected from its bed and its raw surface lined with a thick split graft from the thigh, using plasma and thrombin topical to fix the graft in place. The flap was then returned to its bed for two weeks. Ultimately, the flap was transferred to the face and a total rhinoplasty accomplished after the manner of Tagliacozzi.

This procedure proved the value of fibrin fixation in flap lining. The graft adhered firmly to the soft fat. When the flap was returned to its bed and lightly tacked in place with a few sutures, no pressure was necessary. There was no difficulty with serum collections separating the buried lining. When lifted at a later date, the graft was perfectly intact and went on to serve its function as a lining for the reconstructed nose.

Summary and Conclusions

1. Fibrin fixation methods of skin grafting, by the techniques of Tidrick and Warner and of Sano were tested in a number of situations selected as typical problems in this work.
2. Both techniques produce fixation of all types of grafts, on both raw and granulating surfaces, in a matter of seconds; and the grafts remained healthy and viable.
3. "Thrombin Topical" has the advantage of being produced commercially in quantity and delivered by the manufacturer ready for use.
4. The elimination of pressure dressings promotes comfort and earlier movement of the part. Tissue maceration does not occur and in the case of children, bedside care is simplified.

Scurvy

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5. In certain areas of strain, such as the interdigital webs and about the mouth, fibrin fixation without pressure dressing involves the risk of graft separation and slough. In such danger areas, the combination of fibrin fixation and pressure should improve results.

6. While the elimination of suturing does avoid troublesome bleeding, the advantage is more than counterbalanced by the difficulties inherent in graft shrinkage.

7. In situations where grafting must be done in the presence of infection, fibrin fixation would seem to be the method of choice.

8. Fibrin fixation is a definite aid in adhering flap linings.

It is the conclusion of the writer that fibrin fixation methods properly applied are a valuable addition to the armamentarium of the plastic surgeon. However, we must heed the ancient proverb to "make haste slowly" and not be first to lay aside the accumulated experience of the past.

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MSMS

IN SPITE of our knowledge regarding the prevention of scurvy, many babies are seen who have this deficiency disease in a mild or a moderately severe form. It is the purpose of this paper to bring once more to the attention of the medical practitioner and public health worker the relative frequency of a deficiency disease that can be completely controlled by adequate measures. There are many articles in the literature on scurvy dealing with the history, incidence, symptomatology, physical findings, x-ray and laboratory findings, and relationship to vitamin C. An excellent description of the disease is given in Brenneman's "Practice of Pediatrics."

Recently three cases of acute active scurvy were seen at this Clinic within one week, two of which were severe enough to be hospitalized for a short period of time. Because of this, it was decided to review the cases of scurvy that had been examined here during the past eight years to see whether or not there could be found some practical points that would be of value to the general practitioner and public health workers to more effectively prevent this disease which is so painful to the child afflicted with it. From 1937 through 1944, sixty-eight cases of scurvy have been seen—of these, twenty-four were admitted during 1943-1944. It is apparent that there is no decrease in the number so diagnosed during the last two years, but it should be noted that more cases have been seen during the past two years than during any of the preceding years.

TABLE I. AGE INCIDENCE

Infants Under 6 Months.....	7
Infants 6 Months to One Year.....	58
Patients Over One Year.....	3

Table I shows the age incidence in this group of patients which corresponds to the other studies which have been reported. Scurvy is a disease that occurs predominantly during the latter half of the

first year of life when the baby is very likely to be on a milk formula without getting sufficient vitamin C from supplementary foods so frequently not started until the end of the first year, or taken in insufficient amounts to give the child an adequate amount of ascorbic acid. Of the sixty-eight cases, forty gave a history of having had neither orange juice nor tomato juice, nor had they had ascorbic acid. Four infants refused or vomited orange juice when given, and twenty-four infants had had insufficient amounts, ranging from one teaspoonful daily to the juice of one orange, two or three times a week. In one instance, the orange juice had been heated by the mother before she gave it to the child. Vitamin C oxidizes rather rapidly in the presence of heat and air, and there probably was very little vitamin C remaining in the orange juice that was given. Only two infants had been breast fed and these for only three or four months.

TABLE II. PREDOMINANT SYMPTOMS

Irritability	28
Pain on Motion.....	28
Poor Appetite	23
Vomiting	12
Diarrhea	9
Sore Mouth	3

Table II lists the predominant symptoms that had been noted by the mother at the time the child was brought to the hospital. It should be especially noted that irritability, pain on motion, and poor appetite were the outstanding symptoms given in the history. In only three instances was sore mouth noted by the mother, although there were probably more cases that were having some unnoticed tenderness or soreness of the month.

TABLE III. PREDOMINANT PHYSICAL FINDINGS

Rosary	56
Tenderness	35
Swollen and Bleeding Gums.....	27
Malnutrition	24
Pallor	19
Petechia or Purpura.....	7

Table III gives the predominant signs that were noted on physical examination. Of the sixty-eight infants, fifty-six had a scorbutic or sharp rosary. In the remaining twelve cases, it was either not present or not noted. This has been a very helpful physical finding, and it might be well to say a word more about the scorbutic rosary. The swell-

ing in scurvy is felt as a sharp ridge when passing the hand laterally from the sternum to the side of the chest wall. The costochondral junctions feel somewhat like a sharp ridge, and frequently can be seen as well as felt. This beading is usually somewhat tender to pressure. Thirty-five, or slightly more than one-half of the infants, showed generalized tenderness. It is this tenderness which very often causes the infant to be so irritable. Pain is most frequently found in the extremities, particularly the lower extremities, and produce in many instances a pseudo paralysis. It is interesting to note that a number of the infants were referred to this Clinic with diagnoses of poliomyelitis, tuberculosis of the hip, Legge-Perthe's disease, osteomyelitis, and fracture of the femur. The infant may lie with the leg flexed at the hip and externally rotated, giving the impression that there is a disease process in the hip. If there has been much subperiosteal hemorrhage, there may be considerable swelling of the thigh. Even without this hemorrhage there is usually some swelling of the soft tissues. Twenty-seven infants had swollen and bleeding gums, which were either not seen or not noted by the referring physicians. This is practically diagnostic, and should be looked for whenever an infant is seen with generalized tenderness. When teeth are present or are erupting the gums are quite swollen, cyanotic in color, and there is usually a line of hemorrhage at the gingival margin. Swollen gums may be easily overlooked unless careful attention is paid to this finding.

Malnutrition was present in twenty-four of the infants, partially due to the poor feeding history and very possibly exaggerated by the soreness of the mouth which interfered with the child's eating.

TABLE IV. RELATION TO BIRTH HISTORY

Full-term Infants	57
Premature Infants	6
Twins	2

Table IV shows the incidence of the disease and relation to birth history. Fifty-seven infants were full term, six were premature, two—twins, and in the other three instances, the history was not available. No history was available regarding the relationship between the disease and economic status. Scurvy will develop in any infant regardless of economic status, who does not receive adequate amounts of vitamin C in his diet. Anemia was present in twenty-one cases out of forty-four having blood studies. This would be expected in

a group of infants that had not received supplementary foods in the diet. X-ray studies, when taken, showed some or all of the typical x-ray findings of vitamin C deficiency.

Pediatricians recognize the necessity of starting antiscorbutic foods in the infant's diet during the first month of life. Breast-fed babies get ascorbic acid in the mother's milk as soon as nursing is begun. There is no reason why some source of ascorbic acid should not be given early to the artificially fed infant. Physicians and public health workers should see to it that every infant gets vitamin C early in life. Either there is too little knowledge about scurvy or this knowledge is not applied in daily practice. It is commonly known that cod liver oil is necessary to prevent rickets and consequently rickets is seldom seen. It is hoped that this review of the more important clinical findings in scurvy will help to focus the attention of those interested in preventive medicine. There are undoubtedly many cases of mild vitamin C deficiency that go unrecognized. Contact with a family physician several months following a report on one of the above patients revealed that he had found four other cases in his daily practice since our patient had gone home. There are many infants who refuse to take or who vomit orange juice when attempts are made to give it. Fifty milligrams of ascorbic acid, however, can very easily be given daily. This amount of vitamin C costs the patient about one and a half cents a day, so that from the economic standpoint, it is much cheaper than orange juice at prevailing prices. Through maternal education practically every child can be spared this deficiency disease. Physicians and public health workers must take a leading role in such an educational process.

Summary

1. Sixty-eight cases of scurvy have been reviewed to bring to the attention of physicians and public health workers the most common clinical findings in scurvy
2. Irritability, pain on motion, poor appetite, vomiting, diarrhea, and sore mouth were the most common symptoms found in this group.
3. Scorbutic rosary, tenderness, particularly in the lower extremities, malnutrition, swollen and bleeding gums, pallor, and petechia or purpura were the most common physical findings.
4. Some form of vitamin C should be given

(Continued on Page 1358)

The Use of Serous Fluids as an Aid in Diagnosis

By D. H. Kaump, M.D., and W. P. Chester, M.D.
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THE PHYSICAL, chemical, serologic and cytologic characteristics of human serous exudates may be studied in detail. We have had little experience with the chemical and serologic characteristics of these fluids and consequently will deal especially with the cytologic phase of this problem.

Paddock has conducted extensive studies of the physical characteristics of human serous fluids and his conclusions state, "The customary division of transudates from exudates at the specific gravity of 1.016 has been found to be true only in certain diseases." He has found that cardiac, cirrhotic and nephrotic pleural and peritoneal serous exudates usually have a low specific gravity; inflammatory and tuberculous effusions predominately have a specific gravity of 1.016 or more and that the specific gravity of neoplastic effusions is extremely variable. He has also noted quite definite correlation between the protein content and the specific gravity of the fluid.⁹ The erythrocyte and leukocyte counts do not appear to be particularly significant. In our hands the histologic and cytologic study of serous fluids has proven more informative than a study of its physical characteristics.

There are a number of methods by which serous fluids may be prepared for histologic study. Almost all of the reports prior to 1917, with one exception¹, were based on studies of smear preparations. In this method smears are made either before or after settling of the cellular components or after centrifugation.^{7,8} The smears are then stained directly with Wright's stain or by a similar type stain or fixed in formalin and stained with hematoxylin and eosin.

In 1917, Mandlebaum described a method which embodies the principles used by most recent authors. This method consists of complete centrifugation to form a plug of material which may then be handled as any other tissue. This technique has been altered in many minor points and new details added.^{4,5,14} Our own modification consists

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principally of immediate examination of all material obtained at paracentesis.

All fluid which is available should be immediately submitted for examination and the processing of this fluid should be started as soon as it is received. This precaution minimizes degeneration of cells and much of the cellular detail is preserved. The fluid is first centrifuged in 250 c.c. flasks at 1,000 revolutions per minute for thirty minutes. In fluids with scant cellular material a considerable quantity of fluid must be handled so that these large flasks are necessary in initial centrifugation. Next the supernatant fluid is decanted and the residue is put into two 25 c.c. round-bottom centrifuge tubes. These are centrifuged at 1,800 revolutions per minute for thirty minutes or until a definite plug is formed in the tube. The supernatant is again decanted. At this stage, smears of the material may be made from one tube, and to the other tube carefully add 10 per cent formalin solution or any other suitable fixing agent. This is allowed to stand over night for adequate fixation, after which the solid plug may be gently dislodged from the tube. This solid plug is then handled as any other fixed tissue except that it is mounted on the side so that the entire thickness of the material is represented in the final preparation.

Occasionally fluids are excessively bloody and various methods of hemolysis have been suggested. Foote has proposed the use of acetic acid. We have not found this method to be entirely satisfactory and have substituted sodium carbonate powder which is added to the serous fluid up to a final concentration of 0.1 per cent.

We have attempted the use of special stains for mucin and glycogen as have McDonald and Broders but with very little success. Tannhauser has suggested for fluids in which the cellular element is scant that plasma and calcium be added. The scant cellular elements are caught in the meshes of the clot formed and this may then be handled as a plug.

In the study of the prepared slides, there are three predominant cell types which must be differentiated: these are leukocytes, endothelial cells and malignant cells. As a general rule polymorphonuclear leukocytes and lymphocytes may be readily differentiated. Endothelial cells and malignant cells, however, are more difficult to distinguish with certainty, especially if the material is poorly or inadequately prepared.

There are a few characteristics of malignant cells which we have found to be very useful. Among the histologic features we include clumping of the cells, fragments of tumor tissue, and cytologic characteristics, the large nucleus often at the side of the cell, a disproportionately large nucleus, the presence of occasional mitotic figures, an irregular cell outline, a bluish cytoplasm which occasionally contains mucin and tumor giant cells with multipolar mitosis.

Emphasis on these differential features varies somewhat with the author. McDonald and Broders have compiled the frequency of these findings and in thirty fluids containing malignant cells, found clumping in twenty-three and eccentric nuclei in an equal number. Mitosis was found in thirteen instances, while tumor fragments were found in only two cases. In comparison of this survey with the statements of others^{4,15} it is important to note that McDonald and Broders used smear preparations in which one would be less likely to find tumor fragments.

Zemansky emphasized the importance of fragments of tumor tissue, clumping of tumor cells and the altered nucleocytoplasmic ratio. Serial sections of tissue in which there are clumps of cells will occasionally disclose definite acini, in which case the type of cell is easily determined. Jeter, Epps, and Hart repeatedly mention the finding of tumor fragments so that one gains the impression that these authors will scarcely make a diagnosis without this finding. Graham has described tumor giant cells and multipolar mitosis in great detail.

Often in cirrhotic fluids the endothelial cells form sheets of cells which are confused with the clumping noted in malignant cells. In this event the differentiation must be made on cytologic findings almost exclusively. Repeated examination without finding definite tumor fragments is of importance as a negative finding.

It has been our policy to report the probable source of the primary tumor, if possible. We think that while this admittedly may be misleading it is most often a valuable bit of information.

McDonald and Broders have commented on the presence of artefacts which produce some of these findings and have stressed particularly the occasional clumping of non-malignant cells and the fact that vacuolated endothelial cells often simulate mucin containing carcinoma cells.

The material which we present includes only those of peritoneal or pleural origin. This mate-

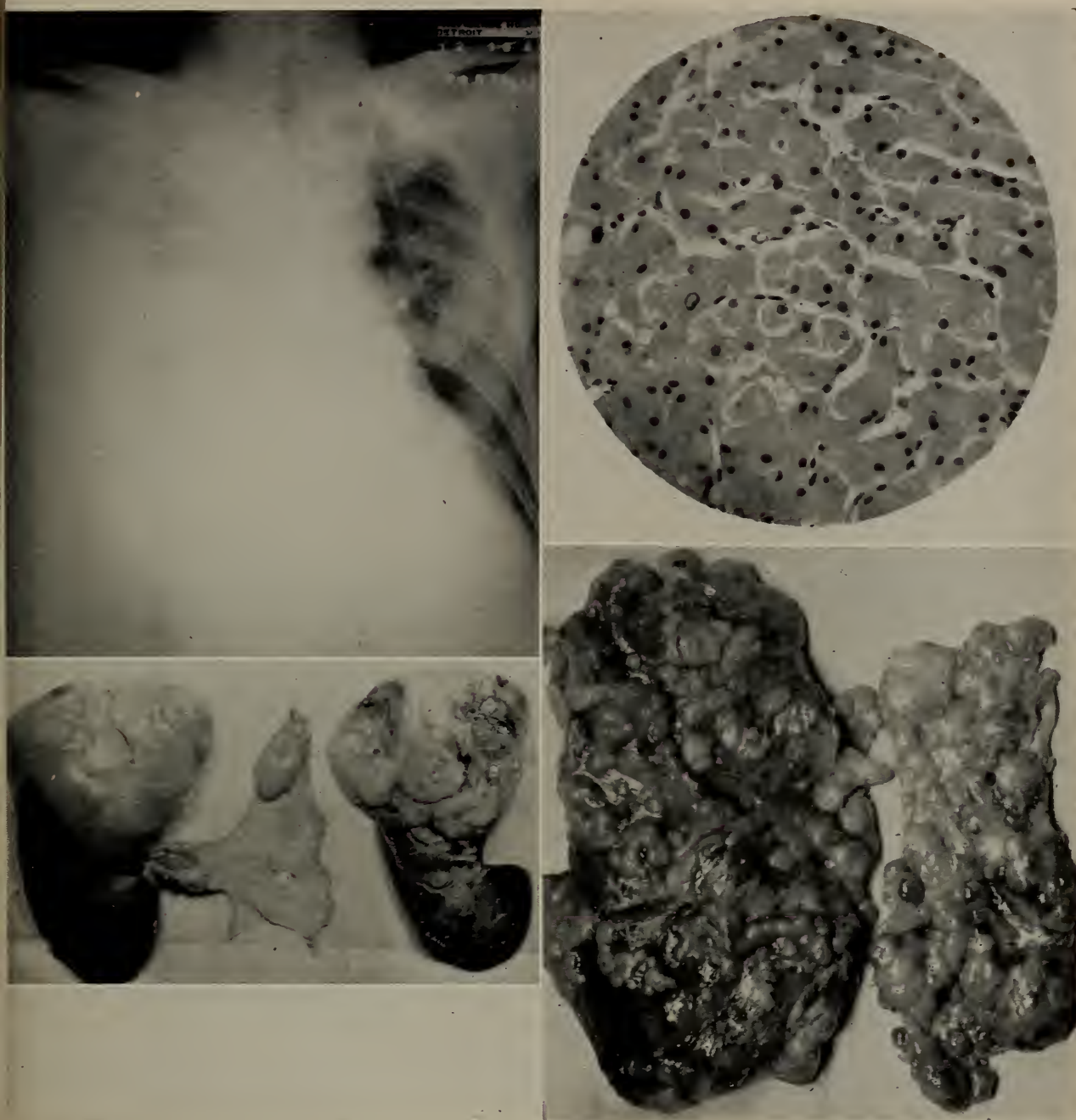


Fig. 1 *a.* Roentgenogram of chest to demonstrate the right pleural effusion. *b.* Photomicrograph of a clump of cells found in the pleural fluid (x 400). *c.* Gross picture of the right kidney with hypernephroma which extended into the vena cava. *d.* Gross picture of the visceral and parietal pleural with extensive metastases.

rial consists of 121 serous fluids from ninety-three patients and was distributed as follows:

DISTRIBUTION OF MATERIAL

	Pleural	Peritoneal	Total
Cases	31	62	93
Specimens	45	76	121
Male	14	27	41
Female	17	35	52
Necropsies	4	26	30

In classification of our material we have considered the diagnosis given on the tissue of prime

importance. Final agreement or disagreement with this diagnosis is based on analysis of the clinical and roentgenologic findings in the unproven group of cases and on the biopsy or necropsy findings in the proven group of cases. For this study we have classified the pathologic diagnosis only as neoplastic or as non-neoplastic without regard to the type of malignancy.

In the examination of pleural fluids we had forty-five specimens from thirty-one patients. The case report of a typical example follows:

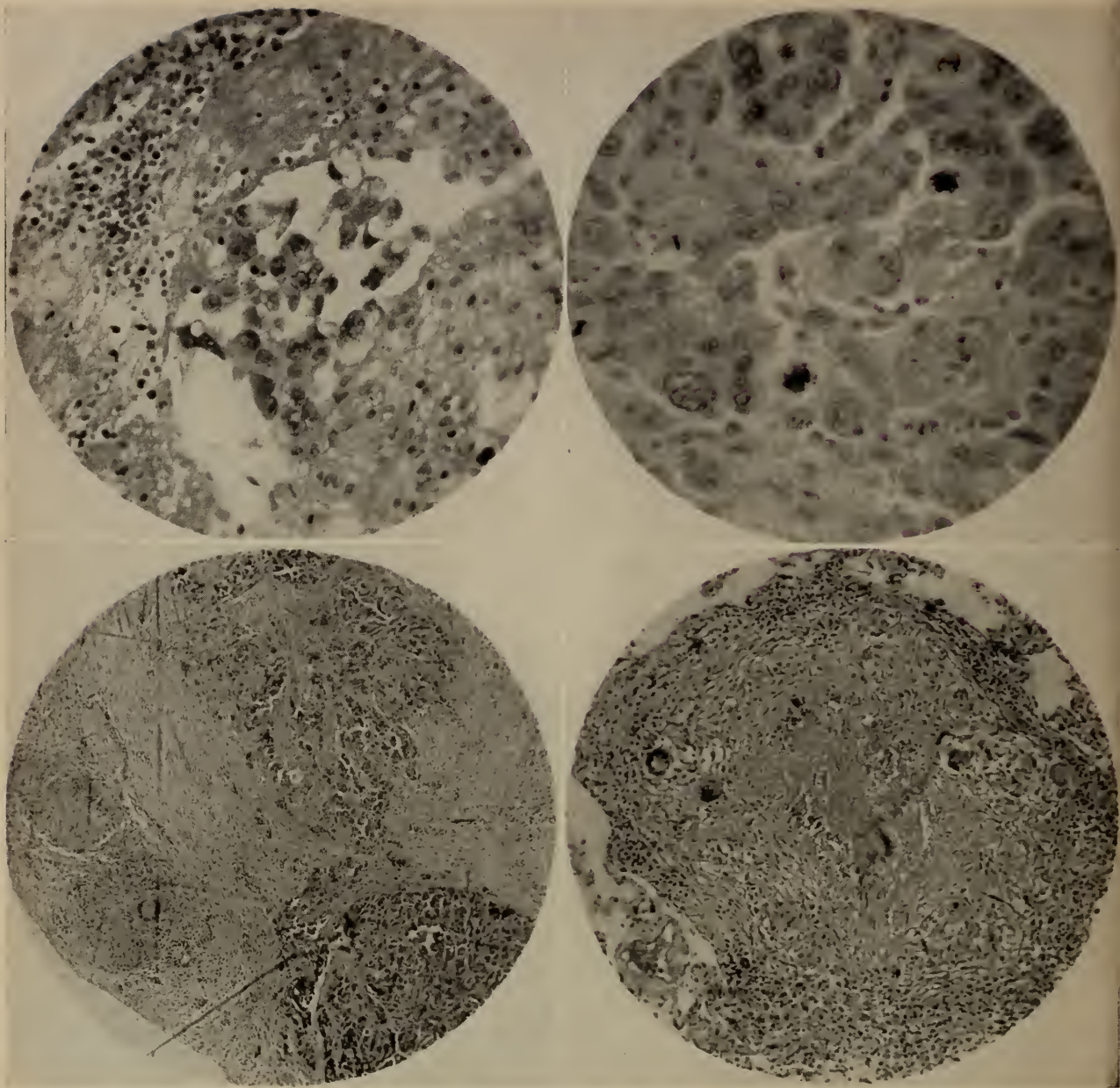


Fig. 2 *a*. Photomicrographs of clumps of cells (450) found in section of the peritoneal fluid. *b*. In some areas of which there were numerous mitotic figures (400). *c*. A section of the peritoneal biopsy with co-existing meta-static carcinoma and tuberculosis (100). *d*. The active tuberculous in the right lung (125).

Case 1.—A white man, aged sixty-six, was first admitted to the hospital for a cholecystectomy because of typical clinical findings. Some time later he was re-admitted with the history that for six weeks he had an occasional cough and for ten days pain in the right flank and lower right chest. On physical examination there was a definite fullness of the right chest with an inspiratory lag on this side. The right chest was flat to percussion with very faint breath sounds. A right pleural effusion was demonstrated roentgenographically (Fig. 1 *a*). This fluid was subsequently removed and clumps of cells were found (Fig. 1 *b*) which were strongly suspected as arising from a hypernephroma. At necropsy a right hypernephroma was found which extended to the renal vein and inferior vena cava (Fig. 1 *c*). The tumor

had metastasized widely and had particularly involved the right lung and the visceral (Fig. 1 *d*) and parietal pleura on this side.

Our material from the pleural cavity is summarized as follows:

PLEURAL FLUIDS			
(Based on pathologic diagnosis)			
	Final agreement	Per- centage	Final dis- agreement
Diagnosed as neoplastic (11 cases, 18 specimens)			Per- centage
Proven cases.....	7	63.7	0
Unproven cases.....	4	36.3	0
Diagnosed as non-neoplastic (20 cases, 27 specimens)			
Proven cases.....	0	0.0	3
Unproven cases.....	12	60.0	5

In our material there were seventy-six specimens of peritoneal fluids from sixty-two patients.

Case 2.—A white woman, aged sixty-one, was admitted to the hospital because of a gradual enlargement of her abdomen over a period of six months. Since the onset of her illness she noted constipation, weight loss (50 pounds) and generalized abdominal pain. During the week preceding admission she began to vomit. On physical examination it was noted that her abdomen had a doughy feel with both intestinal distention and free fluid.

A paracentesis was done and in the fluid were found occasional small clumps of malignant cells (Fig. 2 *a*) with the presence of fairly numerous mitotic figures (Fig. 2 *b*). Because of increasing signs of intestinal obstruction an exploratory laparotomy was done at which time it was noted that the intestine was studded with small nodules and that the loops were intimately bound together. A biopsy was taken of several nodules and in this material the coincidence of carcinoma and tuberculosis was found (Fig. 2 *c*). At necropsy the primary focus for the carcinoma was found to be in the right ovary. The tuberculosis was apparently primary in the right lung (Fig. 2 *d*).

PERITONEAL FLUIDS

(Based on pathologic diagnosis)

	Final agreement	Per- centage	Final dis- agreement	Per- centage
<i>Diagnosed as neoplastic</i> (22 cases, 25 specimens)				
Proven cases.....	18	82.0	0	0.0
Unproven cases.....	4	18.0	0	0.0
<i>Diagnosed as non-neoplastic</i> (40 cases, 51 specimens)				
Proven cases.....	15	37.5	8	20.0
Unproven cases.....	12	30.0	5	12.5

The primary tumor in the cases of neoplastic serous fluids in the males were distributed quite evenly in the stomach (two cases), colon (two cases), pancreas (two cases) and occasionally, in the other organs. In the pleural fluid, however, there were three cases of carcinoma primary in the lung.

The primary tumor in the female patients was most frequently found in the ovary (fourteen cases).

The specificity of this method of diagnosis is of considerable importance.

Zemansky as well as McDonald has reported similar percentages of agreement in cases in which the diagnosis of neoplastic tissue was made (Zemansky 87 per cent, McDonald 80 per cent), as well as those in which a diagnosis of non-neoplastic was made (Zemansky 41 per cent, McDonald 70 per cent).

From these figures it would appear that histologic examination of serous exudates is not only a valuable aid in diagnosis but also is accurate, when a diagnosis of neoplastic cells is made.

SUMMARY OF RESULTS

(Based on pathologic diagnosis)

	Final agreement	Per- centage	Final dis- agreement	Per- centage
Diagnosed as neoplastic... 33		100.0	0	0.0
Diagnosed as non-neoplastic 39		65.0	21	35.0

In our experiences the sources of error have been inadequate amounts of fluids and poorly prepared specimens. It is obvious that all neoplasms which are associated with serous exudates do not involve necessarily the pleura nor peritoneum and hence cannot be diagnosed by this method.

It is interesting to note in our experience that no patient has lived over six months in whom a diagnosis of neoplasm was made on the basis of serous exudate examination.

Summary

We have presented the pertinent findings in our series of 121 serous exudates from ninety-three patients.

We have also indicated the histologic and cytologic characteristics which we have found helpful in the diagnosis of neoplastic fluids.

The degree of accuracy has been very high in fluids which were diagnosed as neoplastic but it must be remembered that a diagnosis of non-neoplastic fluid does not necessarily indicate that no carcinoma exists.

We should also like to stress the importance of utilizing any examination which can yield as satisfactory results as this one has.

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Intramuscular Foreign Protein in the Treatment of Non-Specific Adenitis

By Harry G. Clark, M.D., and
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NONSPECIFIC ADENITIS, particularly of the cervical type, is very common. In spite of its frequency, however, the recommended forms of treatment in our experience have left much to be desired. Help in these cases is particularly important because of the pain and appearance, and the toxic symptoms produced with deleterious effects on the general health. About ten years ago one of us decided to try non-specific protein intramuscularly to get quicker improvement. We have used it consistently, since, in hundreds of cases, both subacute and chronic in type, and have had excellent results with it. The rationale behind this type of treatment is that the foreign protein stimulates the natural body resources to greater efforts by means of a foreign protein reaction which is standard in many other conditions.

An average case of adenitis under the usual care will last anywhere from two to four weeks and even longer. In our practice we give 1 to 3 c.c. of boiled milk intramuscularly, the amount depending on the reaction, tolerance, and age of the patient. Such injections are given 3 days apart until two to six have been given.

The boiled milk is prepared as follows:

Homogenized cow's milk is sterilized in a water bath for twenty minutes in rubber-capped vials with needle inserted to allow full escape of steam. The sterile milk is then kept in a refrigerator and used as required since it will remain in good condition and fit for use for at least a week after preparation.

Following the first injection, the swelling of the glands usually diminishes; also a considerable amount of the tenderness; in a large percentage it is completely gone after the second; and almost all the remainder disappears clinically after the third. Occasionally a case is improved as to the pain, but some permanent enlargement remains.

The common reaction following this serum, is

some redness and pain at the site of injection. We try not to cause a fever; infrequently some patient will report a temperature of 102° F., or a mild urticaria. There have been no severe or alarming reactions in many thousands of treatments for this and other conditions. This applies to either infection or allergic reaction. We have used no supplementary treatment to clear up the original focus of infection, but if still present after the swelling has disappeared, the focus is taken care of to prevent recurrences.

Prior to the use of boiled milk the proprietary preparations aolan and prolan were used with good results. More drastic treatments such as typhoid vaccine and fever therapy have been felt altogether too severe for use in office practice.

We have offered this brief report as a suggestion to hasten the recovery in chronic and subacute adenitis since we have found it practical and much more effective than any other treatment such as the sulfa drugs.

MSMS

ON THE RUN

The potent remedies given us by the modern laboratory cannot be used as placebos.

Sulfonamide anuria is not due to mechanical obstruction but appears to be the result of a hypersensitivity reaction.

With chronological aging the basal metabolic rate tends to fall and the blood sugar level to rise.

It is believed unwise to employ tuberculin negative nurses in sanatoria.

In man the main source of the antipernicious anemia principle is in the upper two-thirds of the stomach.

Cochicine should be used with extreme care because of its depressant effect on bone marrow. It may also produce peripheral neuritis.

Selected by W. S. REVENO, M.D.

Scurvy

(Continued from Page 1353)

every infant beginning with the first month, particularly those fed on an artificial formula.

5. An educational program on the part of physicians and public health workers is essential for the control of scurvy.

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PUBLIC RELATIONS, MICHIGAN STATE MEDICAL SOCIETY

AS DEMONSTRATED for quite some time, the Michigan State Medical Society is a firm believer in scientific progress and in the satisfactory distribution of medical care. It has not only believed in this type of progress but has done something concrete about meeting changing medical needs and has passed on its experiences to surrounding states, several of which have demonstrated their interest by holding regional public relations conferences. Very recently specific recommendations for definite action on a national scale have emanated from The Council on Medical Service and Public Relations of the American Medical Association which, it seems to me, is a most encouraging venture for Doctors of Medicine. This special training places them in a most advantageous position to guard the health of this nation today. One thing is certain: now that such a fine start has been made, more public relations conferences on regional and national levels should be held. The public and the lawmaking representatives should hear the well-considered voice of American Medicine and give their close attention to the profession's definite recommendations in regard to the following projects:

- (1) Prepayment plans
- (2) EMIC program
- (3) Fourteen point program
- (4) Release of returning medical veterans
- (5) Veterans' Administration
- (6) Rural health
- (7) Such other problems as may arise in the future.

In doing so, doctors of medicine will be fulfilling the responsibilities of a good citizenship.

WE NOW come to the New Year. It is my sincere wish that every member of this Society may have reason for cheerfulness and happiness during the year 1946. May it move us forward to an early return of our soldier members.

A. Morrish

President, Michigan State Medical Society



President's



Page



Editorial

THE RECORD FOR 1945

AS THE YEAR ends it is a salutary action to recall what has happened, what of lasting good has been accomplished, what we might have done that we did not, and to think of the future. That is a healthy thought for an individual and for an organization to which we owe much allegiance. If the Michigan State Medical Society during its eightieth year of existence has taken thought and action worthy of its great history, if it has benefited its members and their clientele in a worth-while and lasting degree it has proven its worth. As Alfred Smith said: "Let's look at the record."

WE FOUGHT THE WAR

MOST OUTSTANDING is the war record. Two wars have been won, and the medical profession has played no small part. Ours has been the task to examine and classify uncoun- ted millions of persons to raise our armed forces above twelve million first-class fighting men. We have looked after their health, have attended them in camp and battle, have treated their ills and dressed their wounds. Our armies have been the most healthy on earth, their morale has been the kind that knows no laggard hindrance. If they could get over the first small arms fire area after being injured in battle they were almost assured of living. We are proud of the work of our brothers who served. But their task is about done and we want them home without delay; not sent to Veterans Hospitals or other services for which they did not volunteer.

SOCIAL SECURITY PRINCIPLES

THE MICHIGAN State Medical Society does not believe in the health provisions of the current (third) Wagner-Murray-Dingell Bill. We have fought this thing in every form, from every angle, and we are tired of opposing something that seems to have the "go ahead" sign from the administration and the starry-eyed dreamers. We believe the best way to fight fire is to start a back fire. It is time some positive action be taken by the medical profession. The leaders of the people

think they want a change, and have convinced large masses of the people that a change in the form of rendering medical care to all the people is imperative. Some think it may be inevitable. We firmly believe that tendency should be guided into a way best for public health and economics. Early in 1945 The Michigan State Medical Society Council, through its Executive Committee, appointed a committee to study and propound principles necessary for proper and effective legislative action that would protect the best traditions of medicine, and would safeguard the best interests of the public in regard to their health and welfare. The Drafting Committee has published its suggestions and similar committees of ten other states have acted likewise. Principles have been established that the profession can accept in a program of national health care and in an extended Social Security Service.

For many years Michigan has been suggesting improved relations, and advanced ideas in group thinking, but progress has been slow. This year we have tried out new concepts. In April, 1945, the Michigan State Medical Society acted as hosts at a meeting of the Presidents and Presidents-elect of seventeen State Medical Societies in Detroit. We showed them our plans for remodeling of the Social Security Acts, what our drafting committee thinks would make the proposed national legislation acceptable. We showed them what our positive action to meet the needs suggested by the propounders of the Wagner-Murray-Dingell Bills has been, namely, Michigan Medical Service, functioning as a great business, offering its services to 868,498 subscribers, one out of every six persons in the state. We showed them our radio public relations program.

Two months later upon invitations of Colorado and California ten State Medical Societies met through their presidents and executive officers at Denver and took action similar to that at Detroit in April. These two meetings have brought forth fruit almost beyond our fondest dreams. First they have aroused many medical men to active participation in directing action that is impending, into channels that will be helpful rather than vague, or ill advised. Our medical leaders everywhere are thinking along surprisingly parallel

lines. One of the most hopeful reactions came from Chicago where the teaching has been that the stimulation of new programs should come from the level of the County Medical Society. The New Council on Medical Service and Public Relations of the AMA has issued its Fourteen Points program, which dovetails so closely with what the States are doing.

The Conference of State Medical Society Presidents and other officers, held in Chicago December 2, 1945, adopted a set of resolutions as the culmination of the above-mentioned program.[†] These resolutions were presented to the House of Delegates of the A.M.A. and adopted on December 5, 1945. Thus a positive program, an aggressive one, has at last been produced, and the profession now has something to offer.

SYMPOSIUM ON SOCIALIZED MEDICINE

WE ARE presenting in this number of THE JOURNAL the papers presented at the First Annual Meeting of Presidents and other representatives of the State Medical Societies, December 2, 1945, in Chicago. The paper, by A. J. Altmeyer, Chairman of the Social Security Board, is rather long, and our space is limited, but we decided to print the whole paper so that our members and the profession in general may know with what we have to contend. We are not refuting any of his statements, but would like to see some proof rather than mere statements.

The Resolutions, published in this issue,[†] were evolved through a long study period by committees of eleven state medical societies. They were approved at the Conference of Presidents and other officers and presented to the House of Delegates, where the Council on Medical Service and Public Relations and the Board of Trustees were instructed to work out a plan that can be presented to the next House of Delegates. This, we fear, will delay for six months an action that must be taken at once, if it is not to be too late.

We have heard medical men, some of them in high places, say that the Wagner-Murray-Dingell Bill need not be feared, that it would never be seriously considered by Congress. How anyone can still have that belief after reading the material we are now presenting is a mystery.

In order to make this material available to all at the earliest possible moment we have stopped the

presses of this number of THE JOURNAL long enough to place these papers in type. We are sorry for the delay, but we believe the material is worth it.

RHEUMATIC FEVER CONTROL

WE HAVE been denied the privilege of holding our Eightieth Annual Session, due to wartime restrictions. While we believed that the good of such a meeting would far overbalance the harm done to wartime travel restrictions, we bowed gracefully and cancelled the best meeting ever planned. However, Michigan took the lead again and held a restricted conference on Rheumatic Fever Control at which medical history was again written. The disease and its diagnosis was studied, numerous papers presented, some of which will be published in these pages shortly, and plans were formulated for the establishing of a far-reaching control. The Committee in charge will soon announce the establishment of Centers for consultation and diagnosis in various parts of the state. This is another distinct "First for Michigan."

INDUSTRIAL MEDICINE AND SURGERY

THE THIRD annual Postgraduate Conference on Industrial Medicine and Surgery was held in the Rackham building in Detroit, April 5, 1945. The papers have been published and the results accomplished have been well appreciated. With the rapid growth of industrial medicine and surgery such meetings are an essential, and will, in the coming years, draw a much larger attendance. Practically every doctor of medicine in the state at some time comes in contact with problems only solved by programs such as we have been giving in these April meetings.

MEN NOT MICE

A NEW CONCEPT of the place of medicine and medical care in relation to certain categories has been pronounced. In past years, when indigency was a state of being indulged in only by a well-known class of unfortunates, the medical men freely and unquestioningly gave of their best to relieve suffering humanity. But time and "progress" recognized these groups and regimented them into objects of attention by bureaucracies who make their living by their "good deeds." The medical profession was sold the theory that cost, or fifty

[†]See page 1, tinted insert facing page 1344.

per cent, was all we should expect for the ever-increasing amount of work being demanded, for these true indigents and others that were regimented into that class, to swell the numbers and show cause for the increasing need of Community and Welfare projects employing vast numbers of "workers." These furnished at one time about 40 per cent of the work of the doctors.

The Michigan State Medical Society Council, at one of its meetings, abrogated the arrangement entered into during the depression years of fifty cents on the dollar, and announced the principle, that, like the grocer and the clothier, the doctor is a purveyor of tangible goods with a tangible value. The indigent who comes under the care of government bureaucrats is no longer indigent, but the ward of an organization which can afford to pay reasonable fees for high class medical care. We are as worthy of full pay as is the bureaucrat who looks after these wards, or the dispenser of housing, clothing, or food. A committee was appointed to study this matter in all its details, and this committee presented its report to the House of Delegates in September. The Report recommended a minimal schedule of fees for all governmental agencies. The Report was accepted. (Published in the Proceedings of the House of Delegates.) This action has given us a weapon whereby we no longer must be at the mercy of bureaucrats and bargainers, or be regimented by government in matters of medical practice. We have the principle expressed and the means of implementing it.

MICHIGAN MEDICAL SERVICE

DURING THE YEAR the position of Michigan Medical Service has been wonderfully improved financially, and in every other way. Its popularity is unquestioned, its reserve is substantial, and its services have been much extended. Michigan Medical Service and Michigan Hospital Service constitute the largest joint plan of voluntary nonprofit producers co-operative in the field of health service, and are operating at the lowest overhead cost. Both organizations have safe surpluses wisely invested in government bonds, have their claims paid up to the workable limit, and Michigan Medical Service is paying doctors more than \$400,000 per month.

These are a few of the major accomplishments of medical men in Michigan during the year just ending. It is imposing, and a challenge to the

next year. We know much lies in the future. Many grave problems must be solved. But we approach them in confidence.

ONE WAY TO REDUCE CANCER MORTALITY

IT IS MOST distressing in these days of education of the laity as well as of the profession in the early danger signals of malignancy to encounter far too many patients whose lives are needlessly jeopardized or destroyed through somebody's negligence. Approximately half of all of the carcinomas occurring in the human body are located in the digestive system, and over half of those occur in the colon, rectum and anus. The majority of the malignancies occurring in the lower large bowel are found in the ampulla of the rectum, or at the recto-sigmoid. Both of these latter sites are within easy reach of the examining finger. It, therefore, seems incredible to one who is called upon so frequently to treat patients with malignancies of the lower bowel to find that so many cases, particularly in their early stages, are entirely overlooked by otherwise careful physicians.

For many years, we protologists have been preaching the gospel of early and complete examination of the anus, rectum and colon in all patients who exhibit symptoms of any change in their digestive physiology and bowel regularity. We have also recommended that all cases of loss of weight, fatigue, loss of appetite, and of anemia be subjected to a complete examination of the lower intestinal tract in conjunction with the general physical check-up. We still meet tragic evidences of the fact that this is not being done, and, many patients, who complain of symptoms of a general character such as have been noted above as well as of anal discharge, whether mucus, blood stained, or frank hemorrhage, may be the victims of malignancy still early enough to be successfully removed by appropriate surgery. Unfortunately, the symptom of pain is not present in neoplasms located above the anal canal until they have progressed to a point where obstruction is present and operation has been too long delayed.

Too often patients who complain of digestive disturbances are subjected to a so-called gastrointestinal x-ray examination before a proctoscopic or sigmoidoscopic examination suggests itself to the examining physician. Unfortunately, malignancies, particularly early malignancies situated in

the rectal ampulla, may not be shown by means of the opaque enema and are, therefore, not infrequently overlooked.

Malignancies which occur on the anterior or posterior surfaces certainly will not show a filling defect unless the patient is manipulated in the oblique position and not always then. It is embarrassing to be forced to inform a patient who has had a complete gastro-intestinal examination that he has a growth within easy reach of the examining finger or which could easily be visualized through a proctoscope or sigmoidoscope. That this occurs in the practice of every proctologist too many times yearly can be easily proved by "looking at the record."

When, oh, when is the general practitioner going to be induced to make a rectal examination as part of his routine check up of every patient whether he presents symptoms pointing to the

rectum or not? When, oh, when is the physician going to cease prescribing soothing suppositories and ointments for ano-rectal conditions which can never be cured by such treatment? When, oh, when is the physician going to stop lulling a patient into a false sense of security by the use (or misuse) of the above sedative measures when perhaps an early carcinoma is lurking just above the hemorrhoids or fissures for which he is prescribing suppositories and ointments?

An earnest plea is offered for the inclusion in every examination of every patient who presents any of the symptoms mentioned above, as well as in those patients who come for a periodic physical examination, the same thorough examination of the anus, rectum and colon as one would give in checking up the cardio-vascular and respiratory systems.

LOUIS J. HIRSCHMAN, M.D.

Resolution re Veterans' Administration Hospital Contract

WHEREAS, The U. S. Veterans' Administration has been circularizing hospitals with a form of contract entitled "Proposal for the Hospital or Sanatorium Care of Beneficiaries of the Veterans' Administration" which in effect is an offer on the part of a hospital which executes this contract to furnish and sell to the Veterans' Administration not only hospital services but medical and dental care as well and

WHEREAS, under this contract, payment is made not to the doctor of medicine or to the doctor of dentistry but directly to the contracting hospital, and

WHEREAS, this agreement is one for the practice of medicine by hospital which is clearly objectionable and illegal, therefore be it

RESOLVED, that firm objections be made to the form of the Veterans' Administration's present contract with hospitals, and that the American Medical Association be respectfully requested to endeavor to have the Veterans' Administration immediately modify the contract to avoid the patently illegal practice of medicine by hospitals, and be it further

RESOLVED, that The Council of the Michigan State Medical Society be instructed to make known to the Michigan Hospital Association the serious objections of the Michigan medical profession to this type of contract which calls for the practice of medicine by a hospital, and that the Michigan Hospital Association be requested to urge its individual member hospitals not to enter into such a contract and to terminate existing agreements of this type as soon as possible, and be it further

RESOLVED, that copies of this resolution be published as a special article in THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, be forwarded to the Editor of *The Journal of the American Medical Association* and to the Secretaries and Editors of all other State Medical Societies.

PROCEEDINGS OF THE MSMS HOUSE OF DELEGATES — 1945

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MICHIGAN STATE MEDICAL SOCIETY

Eightieth Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

Book-Cadillac Hotel, Detroit, Michigan

(Concluded from November Issue)

Tuesday Evening Session

September 18, 1945

The meeting convened at eight-twenty o'clock, P. M. P. L. Ledwidge, M.D., the Speaker, presiding.

THE SPEAKER: The House will please come to order.
Is the Chairman of the Credentials Committee ready to report?
J. J. O'MEARA, M.D.: Mr. Speaker, I hold in my hand the names of more than 40% of the delegates, to make a quorum of the Michigan State Medical Society House of Delegates, fifty per cent of whom do not come from any one county.

THE SPEAKER: Unless there is objection from the House, this report will be accepted as the roll call.

The first item of business is to go on with the report of the Reference Committee on Resolutions. Dr. DeTar.

IX-6 (c). UNIFORM FEE SCHEDULE— VETERANS

JOHN S. DETAR, M.D.: This is the second resolution regarding the fee schedule. Dr. Babcock introduced the resolution and requested that it be withdrawn inasmuch as the scope was covered by the resolution by Dr. Brunk. However, as it was presented on the floor, I will have to read it again for your action.

"WHEREAS, Various Government Agencies are now predicting an unemployment total of 8,000,000 workers, and

"WHEREAS, The medical facilities of municipal, county, state and Governmental Agencies will be sorely taxed during such a period of unemployment, and

"WHEREAS, The returned medical veteran will be anxious to re-establish his old practice or build up a new one, be it therefore

"RESOLVED, That the House of Delegates of the Michigan State Medical Society hereby empower the Council of the Michigan State Medical Society and Michigan Medical Service in co-operation with the various municipal, county, state and Governmental Agencies interested, to formulate just and equitable fee schedules and procedures, such schedules to be subject to revision by the House of Delegates annually."

This resolution was considered by the Committee, and the Committee recommends that the resolution be not accepted.

I move the acceptance of this recommendation.

L. W. GERSTNER, M.D. (Kalamazoo): I second the motion.

THE SPEAKER: Is there discussion? All in favor say "aye"; opposed. The motion is carried.

IX-6 (d). MEDICAL VETERANS' READJUSTMENT PROGRAM

JOHN S. DETAR, M.D.: The next resolution is by Dr. Babcock, regarding the use of the funds allocated to pay for counselling services to returning veteran doctors of medicine.

The intent of the resolution was preserved, only minor changes being made in the context. With your permission, I shall read the resolution as amended.

"Whereas, There is \$16,723.75 in the State Medical Society Treasury for postwar planning, and

"Whereas, There has not been the need for a paid counsellor on postwar adjustments for returned veteran doctors of medicine, and

"Whereas, It now appears that there is a scarcity of physicians, and that this scarcity will continue for several years because of the increased ratio of physician deaths as compared to physicians graduating, and

"Whereas, It now appears that the releases from the armed forces will be gradual, with many electing to stay in our greatly enlarged Navy and Army, as well as entering the Public Health and Veterans' Service, be it therefore

"Resolved, That each component county society set up its own County Society Information Bureau to

the extent needed by that Society, in caring for its returned veteran doctors of medicine, and also be it further

"Resolved, That the money now in the special fund in the Michigan State Medical Society Treasury be used through the Executive Secretary's office, at the discretion of the Executive Secretary, with the approval of The Council; that pertinent information be published from time to time in the Michigan State Medical Society Journal, and that all information be readily accessible to the various component County Societies, and to all discharged veteran doctors of medicine, and that the Postwar Planning Committees of the various County Societies co-operate with the State Society in assembling data for use by the State Society and themselves; that it shall be the duty of the Executive Secretary of the Michigan State Medical Society to collect data on residencies, refresher courses, locations to practice, methods of securing loans to establish practice, or for educational purposes, and all other matters pertinent to the problems of the returned veteran doctors of medicine."

This resolution was unanimously approved by the Committee, and, Mr. Speaker, I move the adoption of the resolution as amended.

THE SPEAKER: Is there a second to the motion?

H. L. MORRIS, M.D. (Wayne): I second the motion.

R. A. JOHNSON, M.D. (Wayne): What happened to the sixteen thousand dollars?

JOHN S. DETAR, M.D.: The sixteen thousand dollars? "That the money now in the special fund in the State Medical Society Treasury be used through the Executive Secretary's office, at the discretion of the Executive Secretary, with the approval of The Council."

R. A. JOHNSON, M.D.: For what?

JOHN S. DETAR, M.D.: "That pertinent information be published from time to time in the Michigan State Medical Society Journal, and that all information be readily accessible to the various component County Societies, and to all discharged veteran doctors of medicine." In other words, that it be used for the purposes of sustaining veterans in their rehabilitation at the discretion of the Executive Secretary, on advice of The Council.

T. K. GRUBER, M.D. (Wayne): There are two resolutions on this subject. I know that in many times past, and in the House of Delegates of the American Medical Association as well, when there are two resolutions on a subject they are very frequently reported by the Reference Committee in one motion. It would seem to me that we might get this thing gummed up a bit if one resolution says to do one thing and another resolution says to do another thing. I think the whole matter should be handled in one resolution.

JOHN S. DETAR, M.D.: It is.

T. K. GRUBER: No, but it isn't. I still think it is possible to do that.

As to the question of what is to be done with the money, I believe in some conversations that the delegates had at Wayne they sort of felt that this money might be held in escrow for some emergency. How many medical officers from Michigan are there in service now?

THE SECRETARY: There are 2,287.

T. K. GRUBER, M.D.: Over 2,000. That would be about \$8 apiece, which wouldn't be a snap of the finger, in the matter of loans. I know the conversation I have heard, and that has been had, is that there is a question in the minds of some of the Wayne group as to whether this money should be allowed out of the treasury until something more pertinent and something more appealing and something more deserving comes along.

R. S. BREAKEY, M.D. (Ingham): This resolution has nothing whatsoever to do with loans. Dr. Gruber's comment is not pertinent to the question.

PROCEEDINGS OF HOUSE OF DELEGATES

T. K. GRUBER, M.D.: I still believe that my comments originally were pertinent. I said there were two resolutions and they should have been handled in one, instead of two separate resolutions.

THE SPEAKER: Gentlemen, we will ask the chairman of the Reference Committee on Resolutions to read this resolution in its original form—first, the one you just discussed.

JOHN S. DETAR, M.D.: The original form of this resolution read as follows:

"WHEREAS, There is now approximately \$16,723.75 in the State Treasury for postwar planning, and

"WHEREAS, There has not been the need for a paid Counsellor on postwar adjustments, and

"WHEREAS, It now appears that there is a scarcity of physicians, and that this scarcity will continue for several years because of the increased ratio of physician deaths as compared to physicians graduating, and

"WHEREAS, It now appears that the releases from the armed forces will be gradual with many electing to stay in our greatly enlarged Navy and Army, as well as entering the Public Health and Veterans' Service, be it further

"RESOLVED, That each component county society set up their own County Society Information Bureaus to the extent needed by the Society in caring for its returned medical veterans, and also be it further

"RESOLVED, That the money now in the State Treasury be used in the formation of a State Information Bureau on Postwar Planning. That pertinent information be published from time to time in the State Journal and that all information be readily accessible to the various component County Societies and to all discharged medical veterans. And that the Postwar Planning Committees of the various County Societies co-operate with the State Society in assembling data for use by the State Society and themselves. That it shall be the duty of the State Information Bureau on Postwar Planning to collect data on residencies, refresher courses, locations to practice, methods of securing loans to establish practice or for educational purposes and all other matters pertinent to the problems of the returned medical veteran."

THE SPEAKER: Now, for the purpose of information only, read the other resolution that has to do with the loan. This is for information only, and we will not discuss it until afterwards.

JOHN S. DETAR, M.D.: This is the resolution by Dr. Perkins covering the same subject as the preceding resolution by Dr. Babcock.

"WHEREAS, The sum of \$16,723.75 is now being held in trust as the total accumulation from the special assessment of \$5 levied by the 1944 House of Delegates of the Michigan State Medical Society for the Michigan State Medical Society Medical Veterans' Readjustment Program, including payment for the services of a full-time Counsellor and Advisor on postwar adjustment, such as the problems of (a) relocation, (b) postgraduate education, (c) finances; and

"WHEREAS, The services of Procurement and Assignment Service, together with those of the present Placement Bureau of the Michigan State Medical Society can and are adequately caring for the medical veteran's relocation problem; and

"WHEREAS, The combined postgraduate program integrated by the Michigan State Medical Society, the medical schools of Michigan, and other teaching institutions is and will adequately handle the medical veteran's postgraduate needs; and

"WHEREAS, The only probable problem of the medical veteran who returns to Michigan may be that of finances; and

"WHEREAS, The present Medical Veterans' Readjustment Program Committee and the administrative personnel of the Michigan State Medical Society are able to handle this phase of the veteran's problem, therefore, be it

"RESOLVED, That a Counsellor and Advisor for the Michigan State Medical Society Medical Veterans' Readjustment Program be not employed and thereby, through additional and unnecessary administrative costs, deplete the fund; and be it further

"RESOLVED, That the trust fund be held in trust, as at present, and be used only for loan purposes to returning medical veterans, where needed."

Your Resolutions Committee, in considering the second resolution, feels that the amount of money in the special fund is too small to be of use as a loan fund, and that the previous resolution adequately handles this entire matter, and therefore recommends that this resolution not be adopted, and that the first resolution should be adopted.

R. A. JOHNSON, M.D. (Wayne): I call for the question. THE SPEAKER: Then the motion was to vote on the original resolution as amended, the one presented by Dr. Babcock, that calls for one way of handling the \$16,723.75 which is held now in the State treasury.

J. M. ROBB, M.D. (Wayne): I second the motion.

H. H. RIECKER, M.D. (Washtenaw): I think this money should be used for educational purposes for the veteran returning, and the Council should be so instructed.

THE SPEAKER: Do you feel this resolution does not state that?

H. H. RIECKER, M.D.: Not quite.

THE SPEAKER: May we have the resolution of Dr. Babcock's, the original resolution, read once more as amended by the Committee. If there is anything you want to add, then please add it by amendment, because we will have to consider the two separately under the circumstances.

JOHN S. DETAR, M.D.: Will it be satisfactory to read only the resolved?

THE SPEAKER: Yes.

Dr. DeTar read the last two paragraphs of the resolution, as appearing on pages 151 and 152 of the Proceedings.

THE SPEAKER: For point of clarification, while it is not worded that way, it means leaving it in the hands of The Council because the Executive Secretary never spends any money that is not voted by The Council.

(Calls for the question.)

All in favor of adopting the resolution as amended by the Committee say "aye;" opposed. The motion is carried.

IX—6 (e) MEDICAL VETERANS' READJUSTMENT PROGRAM

JOHN S. DETAR, M.D.: Concerning the second resolution on the same subject, by Dr. Perkins, the Reference Committee recommended that this resolution not be adopted.

Mr. Speaker, I move the adoption of this recommendation.

THE SPEAKER: You had better read the resolved.

JOHN S. DETAR, M.D.: "RESOLVED, That a Counsellor and Advisor for the Michigan State Medical Society Medical Veterans' Readjustment Program be not employed and thereby, through additional and unnecessary administrative costs, deplete the fund; and be it further

"RESOLVED, That the trust fund be held in trust, as at present, and be used only for loan purposes to returning medical veterans, where needed."

W. B. HARM, M.D. (Wayne): I second the motion.

THE SPEAKER: The motion is that the resolution be not adopted. Is there any discussion?

IX—6 (f) MEDICAL VETERANS' HOME-OFFICE CARE

All in favor say "aye;" opposed. The motion is carried.

JOHN S. DETAR, M.D.: The next resolution is by Dr. Babcock and it is aimed to facilitate better medical care to returned veterans, who are not doctors of medicine, by enlarging the medical services available to veterans to include office, home, and hospital care in the veterans' home locality. This resolution also provides for a united front for all Michigan doctors of medicine in handling the question of fees charged for services to veterans, through the medium of the Michigan Medical Service, which would act as a clearing house, and which would handle the detail of the care of veterans' cases at cost.

You will note that this resolution states very frankly the willingness of the medical profession to co-operate with existing veterans' organizations and leaves the next step on this immediately pressing problem to the Veterans' Administration.

The resolution reads as follows:

"Whereas, The Veterans' Administration is having difficulty in handling the many medical problems of the returned veterans, and

"Whereas, The present difficulties will be greatly increased now that the war is concluded so that the present overtaxed facilities will be completely overwhelmed, and

"Whereas, The location of the various Veterans' Hospitals often presents extreme difficulty to veterans in obtaining treatment, and

"Whereas, The cost of transportation to the Government for transportation of the veteran to and from the various veterans' facilities would be eliminated, and

"Whereas, The time lost to the veteran in transportation to available veterans' facilities would be largely eliminated, and

"Whereas, The cost to the Government to build additional necessary veterans' facilities would be very large and consist of unnecessary duplication, if existing local civilian facilities are not used, and

"Whereas, The proper professional personnel to staff and maintain additional facilities would be difficult to secure, and

"Whereas, The veterans' facilities for the care of the ambulatory veteran are inadequate and poorly located, and

"Whereas, At present ambulatory patients are now unnecessarily hospitalized to the distaste of the veteran plus additional expense to the public, and

"Whereas, Such a policy necessarily reduces an already limited bed capacity thus often depriving the acutely ill veteran of bed space, and

"Whereas, We, the physicians of the State of Michigan, firmly believe that a policy of forcing a patient into the care of one not of his own choice

is against the Democratic principles upon which this country is founded, and

"Whereas, The veteran could be well cared for by his family physician with a saving of time, convenience and expense, and

"Whereas, We, the physicians of the State of Michigan, heartily endorse the maintenance of the family physician-patient relationship, and

"Whereas, There is a medical organization in the State of Michigan known as Michigan Medical Service that maintains aforesaid relationships, and

"Whereas, The Medical Society of the State of Michigan has been approached by various veterans' organizations requesting it to obtain the co-operation of the doctors of Michigan, be it therefore

"Resolved, That the doctors of medicine of the State of Michigan urge that the Veterans' Administration avail itself of the medical services of all the doctors of medicine of the State of Michigan through the Michigan Medical Service, furthermore and

"Whereas, There is an urgent need for this action, be it therefore further

"Resolved, That the House of Delegates of the Michigan State Medical Society hereby empower the Council of the Michigan State Medical Society and Michigan Medical Service, in co-operation with various veterans' organizations and with the Veterans' Administration, to formulate a just and equitable fee schedule and procedure."

(The Reference Committee has added this additional phrase):

"And that the provisions of this resolution be used in whatever manner deemed proper by The Council of the Michigan State Medical Society."

"The fee schedule is to be subject to revision by the House of Delegates annually, or in special meeting called for that purpose."

This resolution was passed by the Resolutions Committee. Therefore, Mr. Speaker, I move the adoption as submitted.

(The motion was seconded by W. B. Harm, M.D., Wayne, and carried.)

IX-6 (g) MEDICAL VETERANS' BENEFITS

The next resolution is a resolution by Dr. Babcock, requesting the Congress of the United States to change the Provisions of the GI Bill of Rights to make it possible for a discharged veteran to take a short refresher course at government expense. At present the government will pay up to \$500 for a thirty-weeks course, but only one-tenth that amount for a three-weeks course, even if the three-weeks course costs a hundred or two hundred dollars. This resolution would correct this unfairness which obviously would work a hardship on doctors of medicine taking short refresher courses on their return from military service.

The resolution reads as follows:

AMENDMENT TO TITLE II, PUBLIC 346, 78th CONGRESS

"Whereas, The Veterans' Administration has interpreted Paragraph 5 of Part VIII, Title II, Public 346, 78th Congress, to mean that for a course of education or training which is set up for a period of time less than thirty weeks, they may pay only that amount which bears the same relation to the maximum amount allowed by the law (\$500), as the length of the course bears to an ordinary school year of thirty weeks, and

"Whereas, The House of Representatives did, on July 18, 1945, pass HR 3749 to amend the Servicemen's Readjustment Act of 1944 and failed to correct paragraph 5 of Part VIII, Title II, Public 346, 78th Congress, so that the Veterans' Administration will not deny to medical veterans full payment of tuition for refresher courses of less than thirty weeks' duration, and

"Whereas, Most medical refresher courses are organized for much shorter periods than thirty weeks, and

"Whereas, Surveys conducted by the American Medical Association indicate that a substantial num-

ber of medical veterans will desire short term refresher training, and

"Whereas, The present law, the so-called GI Bill of Rights, as interpreted by the Veterans' Administration, will deny to such medical veterans the refresher training they desire and which they have been led to believe they would get at Government expense, therefore, be it

"Resolved, That the House of Delegates of the Michigan State Medical Society, in convention assembled, do unanimously protest this discrimination against medical veterans as being contrary to the intent of the Congress and the spirit of fairness of the American people, and be it further

"Resolved, That the House of Delegates requests the members of Congress from the State of Michigan to work for amendment of this law to the end that the full tuition for all courses of education of less than 30 weeks be paid for by the Government for veterans, provided that in no event shall such payments with respect to any person exceed \$500 within any single year, and be it further

"Resolved, That a copy of this resolution be furnished each Senator and Representative from the State of Michigan, and be it further

"Resolved, That a copy of this resolution be furnished each Senator and Representative from the State of Michigan, and be it further

"Resolved, That a copy of this resolution be furnished to the Committee of Postwar Medical Service of the American Medical Association with a request that they use their good offices to further this resolution."

This was passed unanimously by the Resolutions Committee.

Mr. Speaker, I move its adoption.

(The motion was seconded by H. F. Dibble, M.D., Wayne, and carried.)

IX-6 (h) MEDICAL VETERANS' LOANS

Next is a resolution by Dr. Babcock, requesting a reduction of the thirty-day waiting period necessary to obtain a business loan after discharge from the service.

AMENDMENT TO TITLE III, Public 346, 78th CONGRESS
"WHEREAS, The House of Representatives, taking cognizance of the complicated process of obtaining business loans under Title III of Public 346, 78th Congress, did on July 18, 1945 pass HR 3749 to amend this act, and

"WHEREAS, The amendment removes most of the faults of the present Servicemen's Readjustment Act of 1944 except that under Sec. 500 (a), Chapter V, Title III of HR 3749, the new act provides that no loan shall be negotiated until thirty days after the date of the veteran's discharge, and

"WHEREAS, Many medical veterans cannot wait thirty or more days after discharge to re-establish themselves in private practice without undue hardship upon themselves, their families and the community, therefore, be it

"RESOLVED, That the House of Delegates of the Michigan State Medical Society, in convention assembled, recommend to the Senate of the United States the adoption of the amendment of Title III of Public 346 as proposed in HR 3749, provided that the thirty-day waiting period under Sec. 500 (a) Chapter V, Title III of HR 3749 is modified, and be it further

"RESOLVED, That a copy of this resolution be furnished to each of the Senators from the State of Michigan."

The opinion of the Resolutions Committee is that in so recommending to the Senate, the House of Delegates would be entering a field of controversy involving all servicemen, not just Doctors of Medicine, that abolishing the thirty-day waiting period would result in many cases of quick borrowing and rash spending, and therefore the Committee unanimously recommended disapproval of this resolution, and that the resolution not be passed.

I move the acceptance of this report, and recommendation.

(The motion was seconded by W. S. Reveno, M.D., Wayne, and carried.)

IX-6 (i) MEDICAL VETERANS' RELEASE FROM SERVICE

Resolution by Dr. Babcock, requesting early release of physicians from the armed forces.

"Whereas, With the cessation of hostilities the need for medical officers in the armed forces is greatly reduced, and

"Whereas, The President of the United States has announced that the armed forces will be reduced in size by five to seven million men during the next year, and

"Whereas, During the period of the war the civilian supply of physicians has been reduced by some 60,000 who volunteered for military service and was further reduced by more than 20,000 deaths among civilian physicians, and

"Whereas, During the period of the war, replacement of physicians in civilian practice has been practically nil, and

"Whereas, There is an urgent need for the return to civilian practice of many thousands of physicians now in the armed forces, therefore, be it

"Resolved, That the House of Delegates of the Michigan State Medical Society strongly urge that every physician in the armed forces who can possibly be spared and whose duties are not essential to the health and care of our own military personnel be released from service with least practicable delay, and be it further

"Resolved, That a copy of this resolution be furnished to each Senator and Congressman from the State of Michigan, to the Secretary of War, the Secretary of Navy, and to the Surgeon General of the Army, Navy, and Public Health Service, and to the American Medical Association."

The Resolutions Committee added one note, which is not included in the resolution:

"The Resolutions Committee suggests that The Council instruct the Delegates to the American Medical Association to introduce this or a similar resolution at the next meeting of the House of Delegates of the American Medical Association."

Mr. Speaker, I move its adoption.

(The motion was seconded by R. A. Johnson, M.D., Wayne, and carried.)

IX-6 (j) MEDICAL VETERANS' RELEASE BY RATIO

There is another resolution by Dr. Babcock, requesting release of Army and Navy Doctors of Medicine, worded particularly for certain Senators.

"Whereas, The Senate of the United States has seen fit, by Senate Resolution No. 134, to cause a subcommittee of the Senate Military Affairs Committee to investigate the disparity between the ratio of civilian doctors to the population as compared with ratio of medical officers to soldiers, and

"Whereas, In 1942 the War Manpower Commission set up the ratio of one doctor to each 1,500 of the civilian population as a safe ratio for adequate medical care in this emergency, and

"Whereas, It is reliably reported that the civilian ratio is now one to 1,800 while the military ratio is one to 180, and

"Whereas, Since 1942 there have been practically no replacements in the field of civilian medicine despite an annual death rate among civilian physicians of more than 7,000 and an appreciable increase in the total civilian population, and

"Whereas, The Army is in the process of discharging several million men thus reducing the overall need for medical officers, and

"Whereas, Rather than reducing the number of medical officers there has been a net gain of approximately 600 since January 1, 1945, therefore, be it

"Resolved, That the House of Delegates of the Michigan State Medical Society, in convention assembled, commend this action on the part of the Senate of the United States and urge that every effort be made to expedite the return to civilian practice of every medical officer who it is found can be spared from military service without endangering the lives or health of our armed forces, and be it further

"Resolved, That a copy of this resolution be furnished to the Senators from Michigan; to Senator Thomas of Utah, Chairman of the Senate Military Affairs Committee; to Senator Downey of California, Chairman of the Subcommittee appointed to carry out the provisions of S.R. 134 and to the Secretary of War."

The Resolutions Committee has added:

"It is suggested that The Council of the Michigan State Medical Society instruct the delegates to the American Medical Association to introduce this or a similar resolution at the next meeting of the House of Delegates of the American Medical Association."

This was passed unanimously by the Resolutions Committee.

Mr. Speaker, I move its adoption.

(The motion was seconded by E. T. Morden, M.D., Lenawee, and carried.)

IX-6 (k) PEPPER BILL

This is a resolution by Dr. Walker, disapproving of the Pepper Bill, on several counts.

"Whereas, The Pepper Bill in the 1945 Congress (S. 1318), to provide permanently for the health and welfare of mothers and of children from birth to 21 years of age, and for services to crippled children and for other purposes, would remove the administration of these curative medical procedures from established relief agencies and place them under the direction of State Health Departments; and

"Whereas, State Health Departments have specialized in the field of preventive medicine and have little knowledge, training or aptitude for curative medicine which is a wholly different field; and

"Whereas, Existing agencies, such as the Michigan Crippled Children Commission, probate courts and local county social welfare departments, have built up a fine record of service in behalf of the people whom they serve, by state law, and deserve to be continued in the administration of this work; and

"Whereas, States which accept this program must provide matching funds which will of necessity be controlled and expended by a federal bureau, with little or no voice left to the state; and

"Whereas, State laws will undoubtedly be superseded by rules and regulations dictated by a federal bureau; and

"Whereas, Under the Pepper Bill (S. 1318), only those physicians who choose to participate in the program will be available for this socialized medical service—which means that patients desiring their own physicians who are not co-operating will not be permitted a free choice unless they pay the service again (double taxation); and

"Whereas, A minimal ward-type service—which pauperizes all who accept it—is provided under the present Emergency Maternal and Infant Care Program of the United States Children's Bureau, which the Pepper Bill appears to expand and perpetuate in S. 1318; therefore be it

"Resolved, That the House of Delegates of the Michigan State Medical Society disapproves the Pepper Bill (S. 1318 of 1945) as drafted because it will fail to provide competent and adequate medical care for mothers, children, crippled children and others, and because the passage of this proposal in its present form would tend to pauperize patients who are financially independent and to limit free choice of physician."

This resolution was unanimously approved.

Mr. Speaker, I move its adoption.

(The motion was seconded by R. V. Walker, M.D., Wayne, and carried.)

IX-6 (l) CHANGE IN SYSTEM OF MEDICAL CARE

This is a resolution by Dr. Harm, objecting to making a change in the system of the practice of medicine or the system of medical care of the American people on the grounds that doctors of medicine, like all men in service, are unable to voice their views because of military restrictions.

"Whereas, Sixty thousand or practically one-third of all the doctors of medicine of the United States are now in the armed services of their country, and

"Whereas, These physicians have ably proved their loyalty to their country and the American way of life, and

"Whereas, Their services have been highly lauded both by their superior officers and the men they have served, and

"Whereas, At the present time there is much agitation for a change in the system of medical care as practiced in this country, and

"Whereas, These physicians, because of military restrictions at the present time are forbidden to express their views on this matter and have even been threatened with disciplinary action if they should do so; and

"Whereas, The 10,000,000 men they have so faithfully served are under the same restrictions and are unable to express their opinion as to whether they prefer to receive medical care under a socialized system or one of individual enterprise, and

"Whereas, The majority of these physicians and the men served will be released to civilian life with the termination of the war emergency, therefore be it

"Resolved, That the House of Delegates of the Michigan State Medical Society, hereby assembled, request that any decision on a change of the present system of medical care be delayed until such physicians and the men they served are returned to positions in civilian life so that they may be privileged to vote and express their views on this serious problem and the copies of this resolution be sent to the President of the United States and to the Congressional representatives of the State of Michigan."

The Resolutions Committee, added this:

"The Resolutions Committee suggests that The Council instruct the delegates to the American Medical Association, to introduce this or a similar resolution at the House of Delegates of the American Medical Association."

The resolution passed unanimously.

Mr. Speaker, I move the adoption.

(The motion was seconded by L. E. Holly, M.D., Muskegon, and carried.)

(E. A. Oakes, M.D., Vice Speaker, took the chair.)

IX-6 (m) ASSESSMENT (\$25) FOR PUBLIC RELATIONS AND INFORMATION

JOHN S. DETAR, M.D.: Resolution by Dr. Sutton, providing for an assessment of \$25 for public education and public relations.

The Resolutions Committee agreed completely with the purposes of this resolution, and with the need for a continuation of the Radio Committee's work, but voiced the opinion that extension of the publicity program in Michigan should come through newspaper articles and editorials, and not through paid advertising; and that since approximately one-third of the special assessment of \$10 for the year 1945 has not yet been spent, the same assessment (\$10) should be sufficient for the coming year.

The Resolutions Committee agreed that the problem of public relations is a national issue, not a problem for state limitations, and that expenditures for this purpose can be made most effective through a national organization; finally, that the increase in publicity contemplated in this resolution is adequately covered by the resolution previously presented by Dr. Candler.

I will read the resolution exactly as it was presented, with the exception of changing the \$25 to \$10.

"WHEREAS, Some changes in the distribution of medical care, for the benefit of the people, have been effected by the Michigan medical profession through evolutionary methods; and

"WHEREAS, Improvement in medical service and in its distribution is the constant aim of the medical profession which

will never cease its endeavors to bring good medical care to all the people; and

"WHEREAS, Not all the people of our state have been made aware of the salutary efforts of the Michigan medical profession, despite the work of public information performed by the Michigan State Medical Society, especially during the past two years; and

"WHEREAS, One or more of the most progressive state medical societies have markedly increased their dues or levied special assessments to develop a fund sufficient to carry on an adequate program of medical public relations, therefore be it

"RESOLVED, That a per capita assessment of \$10 be levied for the year 1946 for purposes of public education and public relations."

The vote of the Resolutions Committee was unanimously in favor of the resolution as amended.

I move the adoption of this resolution as amended.

THE SPEAKER: The vote is, then, to accept the report of the Committee which recommends the adoption of this with the change from \$25 to \$10.

(The motion was seconded by W. S. Reveno, M.D., Wayne, and carried.)

IX-6 (n) VETERANS ADMINISTRATION HOSPITAL CONTRACT

JOHN S. DETAR, M.D.: This is a resolution by Dr. Darling, in which objection is made to the practice of medicine by a hospital in connection with the Veterans' Administration.

"Whereas, The United States Veterans' Administration has been circularizing hospitals with a form of contract entitled 'Proposal for the Hospital or Sanatorium Care of Beneficiaries of the Veterans' Administration', which in effect is an offer on the part of a hospital which executes this contract to furnish and sell to the Veterans' Administration not only hospital services but medical and dental care as well, and

"Whereas, Under this contract, payment is made not to the doctor of medicine or to the doctor of dentistry but directly to the contracting hospital, and

"Whereas, This agreement is one for the practice of medicine by hospital, which is clearly objectionable and illegal, therefore be it

"RESOLVED, That firm objections be made to the form of the Veterans' Administration's present contract with hospitals, and that the American Medical Association be respectfully requested to endeavor to have the Veterans' Administration immediately modify the contract to avoid the patently illegal practice of medicine by hospitals, and be it further

"RESOLVED, That the Council of the Michigan State Medical Society be instructed to make known to the Michigan Hospital Association the serious objections of the Michigan medical profession to this type of contract which calls for the practice of medicine by a hospital, and that the Michigan Hospital Association be requested to urge its individual member hospitals not to enter into such a contract and to terminate existing agreements of this type as soon as possible, and be it further

"RESOLVED, That copies of this resolution be published as a special article in The Journal of the Michigan State Medical Society, be forwarded to the Editor of the Journal of the American Medical Association, and to the Secretaries and Editors of all other State Medical Societies."

We deleted the words "the commission of an illegal act," thinking it was very controversial, and we have substituted "the serious objections of the Michigan medical profession to this type of contract which calls for the practice of medicine by a hospital."

This resolution was passed by unanimous vote by the Resolutions Committee.

Mr. Speaker, I move the adoption of this resolution as amended.

W. B. HARM, M.D. (Wayne): I second the motion.

R. J. ARMSTRONG, M.D. (Kalamazoo): Is there any information as to how far this signing of contracts by hospitals has gone to date?

E. R. WITWER, M.D. (Councilor from Wayne): I happen to know that there are two of the larger hospitals in Detroit which have entered into an agreement with the Veterans' Administration on that basis.

THE SPEAKER: All in favor say "aye"; opposed, "no." The motion is carried.

IX—6 (o). LICENSURE OF HOSPITAL RESIDENTS

JOHN S. DETAR, M.D.: Resolution by Dr. Bruce Douglas, introduced after very careful preparation for the purpose of providing legally for allowing graduates of medical schools outside the State of Michigan to serve as resident physicians, providing they pass the State Board examinations in medicine within one year.

"Whereas, A great deal of difficulty has arisen in the matter of graduates in medicine from schools in states other than Michigan securing approval as residents in Michigan hospitals because of the present requirements of the State Board of Registration in Medicine and the Michigan State Board of Basic Sciences which are working undue hardships not only upon the graduates but more particularly upon the hospitals of the state, be it

"Resolved, By the House of Delegates of the Michigan State Medical Society that the Michigan Board of Registration in Medicine and the Michigan Basic Science Board be requested to give consideration to the following provision, namely,

"That graduates in medicine from Class A medical schools within the United States, but outside the State of Michigan who may desire to serve as resident physicians in Michigan hospitals be required to present credentials either for examination or reciprocity to the above-mentioned Michigan Boards and that such graduates then be allowed to become residents in Michigan hospitals for one year during which time all necessary steps to complete permanent licensure in Michigan shall have been accomplished. Any graduate failing to qualify and complete registration and licensure by the end of the year must discontinue further residency at once, and until such time as he may complete his licensure, and further be it

"Resolved, That the Michigan State Medical Society House of Delegates go on record that if the Michigan State Board of Registration in Medicine and the Michigan State Board of Basic Sciences through their legal advisers find that the laws governing their authority as now written will not allow such provision for resident physicians to be made, that it be the sentiment of the House of Delegates that such necessary amendments be sought to the respective laws that will allow of such procedure at the earliest moment."

The Resolutions Committee has added this:

"And Be It Further Resolved, That a copy of this resolution be sent to Governor Harry F. Kelly, to the Chairman of the Board of Basic Sciences of the State of Michigan, and to the Chairman of the State Board of Registration in Medicine of the State of Michigan."

The Committee unanimously approved this resolution as read.

Mr. Speaker, I move its adoption as amended.

C. F. BRUNK, M.D. (Wayne): I second the motion.

THE SPEAKER: Is there any discussion?

H. L. MORRIS, M.D. (Wayne): I think it is time for the executive body of the State Medical Society to appreciate one fact.

In the first place, the Registration Board of Medicine in Michigan only functions by the laws which are laid down. We have no authority to change the legislative action which has been enacted.

Secondly, the Basic Science Board of Michigan, has its duty to perform insofar as the law is written.

The Basic Science Board of Michigan is endeavoring, through the Association of Basic Science Boards, similar to the Association of Registration Boards, to simplify and make uniform the respective states' requirements.

For instance, one state may require that in the basic science examinations, that Hygiene is a subject. Another state may say Public Health. Until the state legislative bodies of the Basic Science Boards—that is, those that make the laws relative to that—unify those particular objectionable features, the Basic Science Board cannot have reciprocal endorsement of the states.

The Michigan Board of Registration of Medicine appreciates

the fact that all you gentlemen throughout the state have been embarrassed as well as the Board members themselves by the lack of the personnel in the 9-9-9 basis, which has been a war decision, and to relieve that situation the Board of Registration in Medicine has gone so far as to provide supplemental examinations, which the law does not require, to take care of these individuals who come up for licensure in the state of Michigan.

It is not the prerogative of the Board of Licensure in Michigan to say that any breakdown or any allowances can be made. The statute determines what the requirements are.

The members of the Board of Registration appreciate the fact that we are all in a jam, and that in the 9-9-9 program we have tried to co-operate with the respective hospitals and the profession throughout the state. The Board of Registration in Medicine has agreed among themselves to provide a special examination to take care of these fellows who are passing or are taking their basic science boards at the same time or a few days later.

I hope you all appreciate this fact, that nothing can be done about the licensure of doctors to practice medicine in Michigan, except by legislative action.

If it is your wish to shorten the period or in any way alleviate the situation by allowing men to come in here to practice medicine from other states, and allow them to practice in this state for twelve months or nine months, and then maybe they will pass their boards, maybe they will take their examinations, or maybe they will not. If we are to uphold the standards in the state of Michigan relative to our licensure, it remains for us to adhere absolutely to the rules which have been laid down and the law which is enacted, and adhere to these principles, and not let down the bars insofar as allowing fellows to come in here and practice medicine under the guise of residents and not be licensed.

The State Board of Registration in Medicine has attempted to co-operate throughout this trying period, and if it is the consensus of opinion of this body that legislation should be changed, well, all right, but you cannot do that until the legislature meets at the next session.

L. G. CHRISTIAN, M.D. (Ingham): I would like to ask Dr. Morris if it is the law or the ruling of the Board that he is quoting. I don't believe he is quoting the law. If it is the actual statute, will you read it to us?

H. L. MORRIS, M.D. Dr. Christian, I do not have in my hand the statute of the State, but I am under the impression that the law requires that there shall be a twelve months' residency, and a rotating internship in Michigan before licensure shall be granted.

During the war or this period of emergency the Board has the power to co-operate with the national body, and to go along with the auxiliary program of the 9-9-9. That we did. We reduced the requirements in Michigan from twelve months to nine months during the period of emergency.

L. G. CHRISTIAN, M.D.: I merely asked if it is the law or a ruling of the Board. If it is a ruling of the Board, I want to know about that. I am not particularly interested in it, but after all, I have associated with Judge McClellan for some years and he has been talking about the edicts of the Federal Government, and I want to know about the edicts of the state government.

If this is merely a ruling of the Board, it isn't a law.

H. L. MORRIS, M.D.: It is the prerogative of the Board to make its own rules and regulations. The law states there must be twelve months rotating internship before licensure is granted.

F. J. O'DONNELL, M.D. (Alpena): I think possibly I can answer Dr. Christian's question. He wants to know whether it is the law or a ruling of the Board.

As I understand it, the Attorney General has ruled that anyone can legally practice medicine for twelve months or nine months under the amended war measure without a certificate of medical registration, but that after that he must obtain a certificate of medical registration which would include the residency. In other words, it is a ruling of the Attorney General. Am I right in that?

C. R. KEYPORT, M.D.: No.

T. K. GRUBER, M.D. (Wayne): I am well convinced that this is a good idea. There are, I believe, some 300 residencies in the state of Michigan. There are not enough men graduating from Wayne University and the University of Michigan Medical School each year, so it is not possible for the hospitals of the state to obtain residents.

You men who practice in hospitals want residents. The men are fighting shy of Michigan because they are put to a great deal of inconvenience in getting permission to come here to take their training.

It is a question of the interpretation as to what is the practice of medicine. I personally can see little difference in what the interne does and what the resident does, so far as his relation to the patient is concerned and so far as his relation to you doctors is concerned.

You tell the intern to write an order on the order blank. You tell the resident to write an order on the order blank. You give him certain instructions, and he may think it is necessary to give a patient morphine, to give him a transfusion, to give him this or that or the other thing.

So it comes to the matter of interpretation, whether these people at the end of the first year, who go into their residency in the hospital, are practicing medicine. Apparently the State Board has a little different idea than I have about it. Of course, they are the people who make the interpretation.

Many of the men who go to Wayne University and to the University of Michigan Medical School are not from Michigan. They have no intention of practicing medicine in Michigan. They are going back home. If we could run our residents

through and let them go on back home, we wouldn't create as much competition for the doctors in Michigan as if we require them to get a license, and then they will stay here.

Certainly the hospital today faces the proposition of getting residents. Now comes the matter at the present time of the procurement and assignment to the hospitals of fifty per cent of the residents. I believe the University of Michigan Hospital has between sixty and sixty-five residents. Eloise has thirty-two residents. I have forgotten how many Harper has. I believe there are thirty residencies at Harper. There is a like number at Receiving. They have all been cut in two. Even with that cut it is almost impossible to fill the positions.

Now comes the close of the war, and a lot of these men are coming back. They want to get increased courses or increased training. They want to specialize. They want to prepare for taking their national board. It seems to me some provision ought to be made to get those men back into practice so that they can get their residency and we will be in position at Eloise to take care of about sixteen of these people, and I know in other institutions it will be the same.

Whether we are going to hew to the line in laying down a very fine-haired determination of what is the practice of medicine by an intern or a resident—that on the thirtieth of June he is an intern and he can write on the order blank for a patient, and on the first of July he can no longer write on the order blank for a patient—I don't know. I think that is splitting hairs. I think some sensible and sane regulation should be worked out so that you men who are practicing in these hospitals are going to get good residents and good intern service.

C. R. KEYPORT, M.D.: I know some things about the State Board of Medicine. There are several statutes that we have to abide by. Furthermore, the State Board of Registration of Medicine is given the prerogative of making certain regulations or rules.

The statute says that you must be a graduate of a class "A" school. That you must have had one year of rotating internship. That is very well, and the Board has tried to adhere to that as closely as possible.

During the war emergency the 9-9-9 program was established, and it was established not only in Michigan but in forty-seven other states.

The State Board of Registration of Medicine, in compliance with the requests from the Federation of State Boards, adopted that practice.

Dr. Gruber just spoke about the internship. The State Board of Registration of Medicine has the privilege of making certain rules, and the one rule was that they have one year of rotating internship.

At the meeting of the State Boards of Registration in Medicine in June of this year a resolution was passed whereby the Board has let down that barrier and an interne can interne in the hospital in Michigan for two years.

It doesn't make any difference whether the man comes from California, from Florida, or from Maine, before he is going to practice, if he is interning in Michigan, before he goes back to his particular state to practice medicine, he is going to be licensed in that state.

Michigan has reciprocity with practically all the states in the United States. If he is given two years as an intern, he certainly has had ample time to pass a board and be registered. If he is going to practice in California, there is no reason why he can't pass the Board in Michigan, and through reciprocity be permitted to register or practice in California.

I have nothing to say about these boys. The greatest difficulty is that these interns, if they are able to study four years in medicine and be graduated and take their internship, they should be at least smart enough to know that there are in the United States a number of states which require licensure, and there is no reason why, after two years, they should not be registered. They can be registered in Michigan just as well as they can be registered in their home state because they can get reciprocity.

R. L. NOVY, M.D. (Wayne): May I ask Dr. Keyport one question? I understand in the basic science law, which is necessary in the state of Michigan, there is reciprocity with only two states in the union and not forty-seven states.

C. R. KEYPORT, M.D.: I am glad you brought that up. That is true.

We thought in Michigan, a few years ago, that we were smart and passed a Basic Science Law. We thought it was going to be a panacea for a lot of ills in Michigan and other states have passed basic science laws. There are a few states that have not.

We cannot, in Michigan, do anything with the Basic Science Law because it is on the statutes of the state of Michigan, and until more states adopt the basic science laws, we have just sort of got to throw our hands up and take the consequences.

In June we had a very interesting discussion of this problem with the Chairman of the Basic Science Board of Michigan, and, as you say, Doctor, there are only two or three states that have entered into a federation. The State Boards of Registration in Medicine have a federation which includes approximately 46 or 48 states.

R. L. NOVY, M.D.: Actually, there are only two states in the union from which a doctor can come in here by reciprocity in the Basic Sciences and practice. In 46 states of the union still they cannot do that.

C. R. KEYPORT, M.D.: Yes. And the only way you can change that is to change the Basic Science Law or repeal the Basic Science Law.

B. H. DOUGLAS, M.D. (Wayne): Dr. Keyport has just got to the bottom of this question. The Board of Registration in Medicine is not dealing with this problem in the way that we

believe it could be in relationship to the Board that has the basic science examination to conduct.

May I explain what that actually means? A man may come from another state and serve an internship in one of the hospitals of this state during the past year, complete that internship on June 30, sign up as a resident in another hospital, but he will not have completed anything in the way of his registration at that time. He may not have decided that he is going to stay for that residency until too late to have made it, and there is no requirement during his twelve months or nine months of internship that he should do that.

In the need of getting residents there have been many hospitals that have had to have residents and have no jurisdiction over their internship period to require that they get this finished.

Suppose that man comes to the hospital. He is immediately told, after June 30, that he is not to practice as a resident, even though, as has been indicated here, he might do two years as an intern. Whatever the difference may be, it is rather technical, it seems to me.

However, the situation is that he applies then, on the advice of his new hospital administrator, to get his examinations and all in order. He finds that the examination in basic science is given in October. The examination this year in the Michigan Board for Registration in Medicine was given in September. The Board, as you have indicated, has agreed to give an examination after the basic science examination. However, that will have to be some time after, because it takes a matter of several weeks, if not months, to get the returns on these examinations. At the present time that is no fault of the examining boards, but they are busy men, giving their time for this purpose, and it takes time to get those examinations through.

The possibilities are then that the men that pass this board will not be in the clear, for the examination by the Medical Board, until sometime around the first of the year, perhaps a little earlier.

Be that as it may, these men are not allowed, under the present ruling, to do anything in the way of resident service until that is cleared.

Our whole point is that these rulings could be handled in such a way that time could be given to get clear of these examinations that are required within the twelve-month period, and then they would be in the clear. If a man has not completed it, then he cannot practice in the state of Michigan. Practice, in our mind, is the idea of taking care of patients independently, outside of the jurisdiction of the hospital staff.

R. A. JOHNSON, M.D. (Wayne): Does the resident have to get a license?

B. H. DOUGLAS, M.D.: The resident has to have a license.

THE SPEAKER: Dr. Corbus, as Past President, has the privilege of the floor.

DR. CORBUS: I think the comments have in mind the direction of the thought of the Board of Registration.

Now I offer this for comment, and perhaps as a criticism that I have heard.

From the postgraduate educational standpoint, of postwar education, we are prepared in many hospitals to double our number of residents. We are anxious to do it. We are willing to take them on. The boys who offer their service, however, are concerned over the fact that the financial part enters. They don't expect to graduate and practice in Michigan. They don't expect necessarily to be licentiates of Michigan if they don't plan to practice here.

They have to pay \$50 for the basic science examination. It is a deterrent to their coming in.

THE SPEAKER: Is there further discussion?

H. H. RIECKER, M.D. (Washtenaw): I think we can clarify this problem very simply. This resolution has nothing to do with the 9-9-9 program. It has nothing to do with the practice of medicine in the state of Michigan. Here we are in Michigan, isolated. We are provincial. No teaching hospital can accept a resident of an intern from out of the state (Ohio, Mexico, South America) because of this restriction.

This is simply an attempt to modify our thinking and have an opportunity to accept internes purely for training. It is purely a graduate problem. Can we open the medical schools and the teaching hospitals of our state to graduate teaching of the whole country and of South America and Mexico, or do we have to continue to limit ourselves to the graduates of our own two schools?

That is the sole problem and the sole objective of this resolution, to permit the teaching hospitals to accept residents for training in these institutions if they want to practice medicine anywhere. Then they go to the boards and obtain their licenses.

HENRY COOK, M.D. (Genesee): We had an experience in this connection with one of our residents, and I might state some of the things that we learned from our discussion with Dr. Madison, who is the Chairman of the Board of Registration in Basic Science.

He stated that one of the things that interfered with reciprocity in other states was the fact that in one subject the minimum examination requirement was 75, and in another state the average must be 75 but one or two could be as low as 70 if the other two brought it up. Because of that difference in requirements, reciprocity with that state was prevented. That is just a technicality, but it did prevent the reciprocity in basic science with that state.

Another point was that because of the fact that one state said "public health and hygiene" and another said only "public health" and didn't require it by the title of "hygiene," they could not have reciprocity with that state, although the same subjects and the same data would be examined in. They were not in position in the basic science board to place that interpretation on it.

So it seems to me that the resolution which is introduced is a very timely one to assist the Board of Registration or the Board of Basic Science to clarify some of their actions in the future.

There is one suggestion that I feel rather duty-bound to make to you, and that was requested by the Chairman of the Board of Basic Sciences. That was that in any hospital which enters into a contract with an intern for a year they should have printed upon that contract the rules that are now being discussed here, that an intern, in order to become a resident in the state, must become registered in the state, and explain it to him, so that he could not say that he did not understand it.

So may I request that those of you who have to do with contracts with interns have that law printed right on there, that section of it, and state to them that they must be licensed in Michigan at least for the time being, so they will go about it immediately and become registered, and if they desire residency they will be able to qualify at the end of their internship.

THE SPEAKER: Is there further discussion?

A. E. CATHERWOOD, M.D. (Wayne): I think I can ask a question and if it can be answered it will clarify the situation.

We have a rule, as I understand it, that a man must serve one year's internship before he can get a license. Is there a law that says that if he practices one year and one day he is practicing medicine, and if he practices one day less than a year he is an intern? Is that a ruling of the Board, the State Board of Examiners? Is it on the statute books? Is it an interpretation of the Attorney General? Who makes that decision?

Now, if it is not the statute—

H. L. MORRIS, M.D. (Wayne): It is.

A. E. CATHERWOOD, M.D.: That is what I wanted to find out. I have understood that was the ruling of the Attorney General.

HENRY COOK, M.D. (Genesee): May I answer your question in regard to the Basic Science Board? It is not that they would not like to do some of these things, but they cannot because it is not in accordance with the law and ruling of the Attorney General.

H. L. MORRIS, M.D.: I would like to say one thing about this whole situation. The Board of Registration in Michigan is comprised of ten men who come from all parts of the state. We are equally as interested in our own problems in our own communities as you are in your own problems in your communities.

Dr. Keyport spoke of the letting down of the bars, so to speak, of the minimum and maximum requirements. That was passed upon by the Board last June. The Board has the prerogative of stating what the requirements shall be.

The Board, in view of this jam that we are all in, due to the war and the 9-9-9 program, as comparable to the original twelve months rotating internship, took it upon themselves to establish a minimum and a maximum time of internship. That ruling has not come through from the Attorney General as yet, but the intent of the Board was, as Dr. Douglas mentioned, that at the end of nine months, or eight months, or seven months you may pick your man for residency in the following nine months.

The Board knows that it is practically impossible to get a man from outside the state, who is not interested in Michigan, to become licensed in Michigan. Therefore, the Board said, "We will establish a minimum and a maximum time of this internship, and the boys who are picked at seven or six or eight months, prior to their nine months service, at the termination of nine months and go on, will still have a nine months period to comply with the law." Nothing insofar as I can see is fairer than that, but after the nine months termination of their original first nine months, they must then apply for licensure in this state and take their examinations at the first time the examinations come up, whether it is in basic science or medical practice.

That is the way that the Board has tried to evaluate and tried to compromise and tried to satisfy the demand of every individual and every hospital in the state of Michigan.

Up to the present time, we have no interpretation as to the legality of our procedure, but that, insofar as the Attorney General rules, is the ruling of the Board, and until further action is taken, that will suffice and is legal insofar as our Board is concerned.

R. A. JOHNSON, M.D. (Wayne): Dr. Morris, where is the directive? Is it in the legislature? Is it in your Board? Where is the statement that resident must have his license? That to me is the crux of this matter.

H. L. MORRIS, M.D.: It is in the law.

R. A. JOHNSON, M.D.: What law?

H. L. MORRIS, M.D.: The state laws of the state of Michigan.

R. A. JOHNSON, M.D.: Does the state law say how much time must be spent as an intern?

H. L. MORRIS, M.D.: Twelve months.

R. A. JOHNSON, M.D.: And after that you are a resident?

H. L. MORRIS, M.D.: That is right. You are practicing medicine in this state.

T. K. GRUBER, M.D. (Wayne): I move the previous question.

W. S. REVENO, M.D. (Wayne): I second the motion.

THE SPEAKER: All in favor of the motion say "aye"; opposed. The motion is carried.

JOHN S. DETAR, M.D.: I have two other resolutions.

IX-6 (p). PLEDGE CARDS

This is a resolution by Dr. McClellan to increase the number of physicians in Michigan signing the pledge of non-co-operation with a system of political medicine. It reads as follows:

"Whereas, To date 1,700 members, or approximately 40 per cent of the membership of the Michigan State Medical Society have signed cards pledging

non-co-operation with a system of political medicine, and

"Whereas, The movement in Michigan antedated the similar movement by the American Association of Physicians and Surgeons, and

"Whereas, A signing of such a pledge is completely legal and involves no personal liability, and

"Whereas, Such signing is a demonstration of unity and would immeasurably strengthen the position of the State Medical Society in combating political medicine, be it

"Resolved, That the Council of the Michigan State Medical Society immediately take steps to contact all members of the Society who have not yet signed such a pledge, and be it further.

"Resolved, That the vital necessity of such co-operation be explained to them."

This resolution was approved by majority vote of the Resolutions Committee.

I move the adoption.

(The Vice Speaker took the chair.)

(The motion was seconded by E. T. Morden, M.D., Lenawee, and carried.)

IX-6 (q). AMERICAN HEALTH CARE

This, the last resolution, deals with the branches of the heading art other than what we commonly think of as "Regular Medicine." It is a resolution by Dr. Pino, pointing out the tendency of single ideas in the practice of the healing art to develop into complete systems of treatment, and finally into different schools of thought, in contrast to those of regular medical schools.

This resolution points out the need for doctors of medicine to evaluate such systems of treatment, and asks for a commission to carry out such studies.

In order to avoid controversy, your Resolutions Committee favored four paragraphs, and deleted six paragraphs of the resolution.

Retained is the first paragraph:

"Whereas, By reason of their status in problems of health welfare of the people, Doctors of Medicine by and large are looked to to maintain the best health interests of the people,"

The next six paragraphs are deleted:

"WHEREAS, The magnitude of therapeutics is constantly increasing and whereas schools of thought develop into teaching institutions about single therapeutic procedures,

"WHEREAS, When such schools do develop they find it necessary to expand their concepts and procedures with ever-increasing additions,

"WHEREAS, This necessarily creates a time in the history of every new or renewed therapeutic development when it advances against odds, unsatisfactory to its practitioners and the public alike,

"WHEREAS, Such methods as they use should be evaluated by research and if found good, recognized and incorporated into the programs of the regular medical schools,

"WHEREAS, The evolution of the regular university medical schools demonstrates that the old schools of medicine are made up by periodic amalgamation of separate schools of thought as represented in Allopathy and Homeopathy and even of medicine and surgery which at first developed separately,

"WHEREAS, Therefore the sum total of the history of health care gives us the experience of the past as perspective for the future upon which we ought to be able to advance by reasonable and planned laboratory procedure evaluating scientific problems through research, and other problems through conference,"

This has been retained:

"Whereas, There is evidence that some groups of practitioners outside of the so-called regular schools of medicine as well as within are desirous of holding conferences looking to the incorporation of all proved procedures into one educational channel, thus planning health care and medical education on a basis commensurate with highest standards,"

This has been retained:

"Whereas, Responsible leadership seems to be left to the County and State Societies if courageous action is to be taken in matters of new policy in American health care, therefore be it"

This is retained:

"RESOLVED, That a commission of five members, or whatever number seems best, be named by

the Michigan State Medical Society, including one representative from each of the two medical schools of the state, to study the problems involved, to confer with interested parties and groups, and to report their findings and recommendations to the next meeting of the House of Delegates in 1946."

The Resolutions Committee discussed this resolution for one hour last night and was unable to agree on its value or its wording. A motion to table the resolution was passed.

Then this morning the Committee, feeling that some action of this type was needed, after long discussion, passed unanimously a motion to recommend adoption of paragraphs 1, 8, 9 and 10 of this resolution. Deletions are recommended to avoid controversy, and it is the feeling of the Resolutions Committee that the amended resolution will accomplish the desired results.

I, therefore, move that this resolution be adopted as amended.

W. B. HARM, M.D. (Wayne): I second the motion.

H. L. MORRIS, M.D. (Wayne): I would like to have the man who proposed that resolution discuss before this body what he has in mind relative to the amalgamation comparable to the situation in California. That is what it means. That is the only outstanding example we have in this country today.

I think that this body should be informed, before any vote is taken upon this matter of vital importance, as to what is going on in California.

R. H. PINO, M.D. (Wayne): Do you want that discussed?

(The Speaker resumed the chair.)

THE SPEAKER: The Chair is very reluctant to bring discussion of outside topics at this late hour. If it is of absolute importance so far as this particular resolution is concerned, we will permit it, but I doubt if it is. I am inclined to think if we discuss our problem here, that is enough.

R. H. PINO, M.D. (Wayne): May I say this? I do not know exactly what is taking place in California. I only know what we ought to do here, with many men away from their state and their practices being taken over by other doctors of Medicine. They are going to return and they are going to ask, "What have you men done to protect our practice when we were gone?"

One other thing—The public is confused that the medical profession, which is supposed to lead in the matter of public affairs, constantly sidetracks matters of these other people who are practicing other systems of healing, surrounding single concepts of practice, and then trying to do it all. We say they are not doing a good job. We do not co-operate with them. We need, then, to take the concept that they are dealing with and prove, if we can, through our universities whether it is good or not, and if it isn't, let the public know.

R. S. BREAKEY, M.D. (Ingham): I have been in the committee that sat up until late hours, and in order to complete any business at all, we had to table this resolution until the following morning, because of the prolonged discussion the Chairman mentioned and the discussion really served no point. The majority of the Committee were directly opposed to the resolution as it originally stood. As a matter of fact, if a vote had been held on that, it would have been brought back to the floor of the house disapproved.

It is a matter of record that this is purely a compromise measure.

The question of what California does or does not does not enter into it. It has been simplified by the Committee at some length, and the Committee endorsed it. There were subsequent motions with which Dr. Pino could not find it possible to agree.

I think Dr. Pino's expression of opinion is, within reason, correct, but I think Dr. Morris has something. I voted for this motion, and I am willing to accept it as it is, but I cannot accept Dr. Pino's expression on the matter of what our responsibility is to returning veterans, because a few years ago a number of us simply pledged that an antiosteopathic resolution would be passed by this House, and it was not done. The osteopaths are not mentioned in this resolution, contrary to the wishes of the Committee.

I wish it would be passed, but I do not agree with Dr. Pino.

R. H. PINO, M.D.: May I make one more statement?

We are not saying anything about osteopaths or anyone else. We are saying that whenever a doctor of medicine or a chiropractor or a chiropractor or an osteopath claims something and then builds a practice around it, that the regular school of medicine to which the public looks for direction should take that and evaluate it.

It serves, incidentally, the other purpose, that those who return to their practice and find it has been taken over by any group know that the Michigan State Medical Society is looking to their interest and is thinking about it and has asked that a commission be named to study it; and then to return a report next year. They may come back and say, "Let it all go," but let's say we are doing something about it. Let's study it. People want us to study it.

H. L. MORRIS, M.D. (Wayne): I would like to lay the cards on the table face up.

This situation that Dr. Pino refers to is the situation which means that we take the osteopaths and the chiropractors and amalgamate them into the practice of medicine and licensure them as regular practitioners of medicine. That is what it means.

(Cries of "No.")

Are you familiar with what is going on?

THE SPEAKER: As a point of clarification, the Chair will ask the Chairman of the Resolutions Committee to read the resolution only, not the whereas.

JOHN S. DETAR, M.D.: "RESOLVED, That a commission of five

members, or whatever number seems best, be named by the Michigan State Medical Society, including one representative from each of the two medical schools of the state, to study the problems involved, to confer with interested parties and groups, and to report their findings and recommendations to the next meeting of the House of Delegates in 1946."

(Calls for the question.)

THE SPEAKER: Are you ready for the question? All in favor say "aye"; opposed. The motion is carried.

JOHN S. DETAR, M.D.: I wish to thank the members of the Resolutions Committee who worked late at night and started early in the morning.

Mr. Speaker, I move the adoption of the entire report of the Resolutions Committee.

THE SPEAKER: The motion is to accept the report of the Resolutions Committee as a whole. All in favor say "aye"; opposed. Carried.

(The above motion was seconded by C. F. Brunk, M.D., Wayne.)

E. R. WITWER, M.D. (Council member from Wayne): Am I out of order in asking if there will be supplementary reports submitted?

THE SPEAKER: You are not out of order. They will, and they will be called for right now.

Is there a supplementary report of the Council?

E. F. SLADEK, M.D.: There is no supplementary report of the Council.

THE SPEAKER: Are there supplementary reports of the Reference Committees?

The Reference Committee on Officers Reports? (No supplementary report)

The Reference Committee on Reports of the Council?

IX—2 (g). AMERICAN CANCER SOCIETY— MICHIGAN BRANCH

L. W. HULL, M.D.: This is a resolution that was submitted by Dr. Sevey, Re Executive Committee of the American Cancer Society, Michigan Branch. This was referred back to the Committee for additional information.

The resolution is as follows:

"Whereas, It is the announced policy of the American Cancer Society to appoint as its Executive Committee in each state the Cancer Committee of the State Medical Society; and

"Whereas, In recent years this has not been the case in the State of Michigan; therefore, be it

"RESOLVED, That in order to secure a more comprehensive relationship between the Michigan State Medical Society and the American Cancer Society, Michigan Division, an urgent request be forwarded to the American Cancer Society that it appoint the medical members of the Executive Committee of its Michigan Branch from a list of physicians nominated by The Council of the Michigan State Medical Society."

The Reference Committee on Reports of the Council, having gained additional information on the Resolution re Executive Committee of The American Cancer Society, Michigan Branch, presented by Dr. Sevey, wishes to recommend its adoption.

I move its adoption.

W. W. BABCOCK, M.D. (Wayne): I second the motion.

(The motion was carried.)

IX—2 (h). AMA CONSTRUCTIVE PROGRAM FOR MEDICAL CARE

L. W. HULL, M.D.: Resolution Re American Medical Association Constructive Program of Medical Care.

"Whereas, The Board of Trustees and the Council on Medical Service and Public Relations of the American Medical Association have developed and promulgated a Fourteen Point Program for Medical Care; and

"Whereas, This excellent pattern offers to the nation a positive plan for voluntary health programs that is far superior to any offered the people of this country to date; therefore be it

"RESOLVED, That the House of Delegates of the Michigan State Medical Society congratulate the Board of Trustees and the Council on Medical Service and Public Relations of the American Medical Association and offer them the entire support of the medical profession of Michigan in the furtherance of the Constructive Program for Medical Care; and be it further

"RESOLVED, That the component and district medical societies in this state, and the individual members thereof, be urged to assume the important duty of integrating the American Medical Association Program in their own areas so far as it applies to them, and that each component county society be requested to reserve time at one of its early meetings for an analysis of the Fourteen Points in the American Medical Association's Constructive Program for Medical Care."

The Committee recommends the adoption of this resolution.

I so move.

(The motion was seconded by F. G. Buesser, M.D., Wayne, and carried.)

IX-6 (m). ASSESSMENT (\$25) FOR PUBLIC RELATIONS AND INFORMATION

L. W. HULL, M.D.: Mr. Speaker, may I say just another word?

I would like to inform the delegates that this morning they passed a resolution introduced by Dr. Candler, and if you will allow me, I will read that.

"WHEREAS, The economic trends of medicine point to an increasing effort on the part of organized minorities to regiment medicine, and

"WHEREAS, It behooves the medical profession to take the public into its confidence and tell the people what organized medicine is doing for the public good, and

"WHEREAS, The Michigan State Medical Society has had an urgent need for a full-time public relations counselor to properly inform the public on its ideals and programs, and

"WHEREAS, The officers of the Michigan State Medical Society have long been cognizant of this need, and

"WHEREAS, Such personnel is now available; therefore be it

"RESOLVED, That the House of Delegates recommend to the Council of the Michigan State Medical Society that a public relations man with good newspaper connections be hired immediately."

As I understand it, this was dependent somewhat upon the amount of money, the assessment that was going to be levied on you delegates, and you have just cut that assessment from \$25 to \$10. Yet we relied upon this thing to be taken care of with the \$25 assessment, at least so I am informed.

THE SPEAKER: This is brought up for information only.

E. R. WITWER, M.D.: Mr. Chairman and Members of the House of Delegates—

THE SPEAKER: Dr. Witwer is the Councilor from the Sixteenth District and also the Chairman of the Finance Committee of The Council.

E. R. WITWER, M.D.: I might say that I have been chairman of the Finance Committee only a few days. Consequently, I feel somewhat new in this rather important position.

You have heard discussed on this floor today many problems that have to do with the economics of medicine, and you have designated to your Council, through the action taken by members of the House of Delegates, certain tasks. If you expect your Councils to carry out the wishes of the House of Delegates, we have got to have some money. It is the only thing that keeps the wheels of medicine going.

Dr. Pino has mentioned a great many of our brethren in the practice of the pseudo-arts of medicine, but he forgot to mention the optometrists. I don't know why. He probably knows the reason.

We heard a great deal about the dangers of the inroads that are being made into the practice of medicine. We have heard a great deal about the Wagner-Murray-Dingell Bill and the allied proposed legislation in our National Congress. We have heard something about the E.M.I.C. program.

I am quite sure that you are all familiar with the fact that your Council, during the past year, has taken every possible means to combat these evil influences, and in order to do so, you very kindly last year designated that we could have a certain sum of money.

This year our program is much more ambitious. You will remember that the State Legislature will meet in 1947, and by that time the medical profession must have—not shall have or should have, but must have—a program that is adequate to combat the numbers of bills that will be introduced into the Legislature at that time.

That requires education. It requires education of the medical profession. It requires education of the laity. Other organizations, that are of a nonmedical nature, don't hesitate one minute to put an assessment of \$100 on their members.

I was informed by one of the gentlemen seated at this table, just the other day, regarding a young man whom he knew, who was trained in the work of Diesel motors. He left his home town and went to a distant town to apply for a position. The first thing that the union man confronted him with was this: "If you expect to work in this organization or in this union, you must first of all pay \$150 initiation fee, and in addition to that, you must pay dues of \$5 per month."

That is a mechanics union, gentlemen.

How many of you know what the osteopaths are paying in dues in this city? One hundred dollars a year, and they don't bat an eye in doing it.

Now here we are, gentlemen, confronted with the problem of

providing medical care to the public, and in order to apprise that public of our program, we have got to get to them in certain channels that cost money. Our Special Committee on Radio Activities has done a splendid job during the past year. You are well aware of the beneficial influences that have accrued from the activities of that committee.

Your finances of today, I am sorry to tell you, are reaching a low level, unless you wish to touch some of your reserves, which those who are familiar with the situation feel would be unwise. I might tell you that today your total available cash is approximately eight thousand dollars less than it was one year ago. There are several reasons for that.

First of all, there has been a decided decrease in the number of members who pay dues.

Secondly, we have not had an annual meeting, from which we usually derive a substantial sum in the form of revenue accruing from the exhibits.

As of September 1, there is a total paid membership of the Michigan State Medical Society of 3,362, and there are 1201 members in military service who do not pay dues.

All of that adds up to simply this, that we have less money with which to do a lot more.

The matter of a public relations man was discussed by your Council, and it is deemed advisable by The Council to recommend that action be taken to obtain a reputable, high-class public relations man.

It will also be necessary, gentlemen, to relieve our very much overworked Executive Secretary of many of his tasks by obtaining an assistant. The Society headquarters is no longer adequate to care for the needs of the activities of this Society. We must rent additional space, and we are fortunate, we understand, in having the space directly adjacent to our Society headquarters which will be available in the not too distant future.

Now, to sum up very briefly, we cannot carry out your directives with the funds that you have allocated for the coming year. I am not in position to make a motion, but I suggest, Mr. Chairman, that someone from the floor make a motion for the reconsideration of the resolution on assessment.

THE SPEAKER: Before the Chair entertains such a motion, he would like to have just a little more information. He has asked the Secretary to just remark on one or two points, if he will.

THE SECRETARY: As was stated a minute ago by the Chairman of the Finance Committee, your Council has planned a rather ambitious public relations program for the next year, based on the trends and on the apparent needs.

While the comments of the Reference Committee, that these things could best be done on a national basis, are true, and while we all agree to that, it has been obviously apparent that it won't be done on a national basis, and if and when it is done on a national basis it probably will be too late.

Michigan for some time has been asserting a great deal of leadership, and it has come to our attention that other states are speaking of Michigan with the statement that "This is another first for Michigan." All of our recent innovations in public relations have been looked upon by the other states in the Union as definite progressive steps, many of which are being followed now by many of the states.

The meeting of the state presidents, held in Detroit last April, and the subsequent meeting held in Denver, Colorado, have developed a group of some twenty-five states in the Union who are definitely following Michigan's leadership in all of the activities of a public relations character.

Last year there appeared in the Michigan Legislature and in the Legislature of the state of California, and in a number of other states, a bill sponsored by certain interests, with whom you are familiar, a bill socializing medicine which was hoped would pass at state levels and then an amalgamation of these states' action would have the same effect as if the Wagner-Murray-Dingell Bill passed at the national level.

Two years from now this same proposal will appear again in the legislature of our state and California and the other states that are obviously good guinea-pig states, because of their industrial and other types of setup.

Anticipating this, and realizing that it will call for a great deal of public relations, your Council at its meeting yesterday projected a plan that, together with the increased administrative costs entailed by the return of one of the office force who has been in the armed forces and by the increased office space, figured that the increased assessment of \$25 would be scarcely adequate to put the plan into effect.

With a decrease of the \$25 assessment to \$10, you can see that three-fifths of the projected public relations program in the interest of organized medicine will have to be forgotten.

As an illustration of what this proposed public relations program adopted by your Council yesterday consisted of, I will read part of what it embodied.

1. The employment of a full-time public relations counsel in the executive office, who shall among other things do the following:

- (a) Prepare news releases
- (b) Contact newspaper men—dailies, weeklies—in their home communities
- (c) Contact labor and industry
- (d) Contact individually the Federal Congressmen and the State Legislators in their home communities. Send them periodic letters stressing the value of private medical practice (aided by voluntary plans) as contrasted to compulsory political control.
- (e) Arrange educational conferences with lawmakers, business and insurance leaders, and others interested in public health.
- (f) Stimulate and develop newspaper advertising for county medical societies.
- (g) Develop booklets and printed material showing the benefits

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of American medicine and private practice, aided by voluntary prepayment service programs.

(h) Aid in script writing of MSMS commercial radio programs.

(i) Present addresses on behalf of the medical profession to lay groups.

(j) Aid in organizing the Woman's Auxiliary and take an active part in any activities to preserve private enterprise.

2. Leadership to county societies with their public relations activities of a local character.

3. Continued participation in the Michigan Health Council and its public relations program.

4. Encourage more medical commercial radio and public relations programs in other parts of the country, including necessary contacts with other state medical societies.

5. Stimulation and leadership in the development of a national health congress. That is the same as the Michigan Health Council at the national level. It has to be started by somebody and, as we said before, there is little evidence and hope that it will be started in the parent organization.

In a consideration of this program, together with the present activities of the public relations character, and public relations is carried into the homes of our legislators so that they know what they are voting on when the Legislature meets and we have these pernicious bills, it was estimated in the Council yesterday that \$50 was the probable figure to carry on the work adequately, especially if we might consider the public relations of the non-medical group, labor unions, and so on.

However, the Council did reconsider and cut down the activity and figure where they could eliminate some of the cost and estimated that the \$25 assessment would be the least that they could ask for if they were to preserve your interests in what we chose to call a public relations program. Thank you.

The Chair now will entertain a motion for reconsideration of that resolution.

R. V. WALKER, M.D. (Wayne): I move that we reconsider the motion that was passed a short time ago only on this one point.

(The motion was supported by C. F. Brunk, M.D., and G. L. McClellan, M.D., both of Wayne.)

THE SPEAKER: The point is that in reporting this resolution, the Reference Committee on Resolutions amended the proposed assessment from \$25 to \$10. We are asking now for reconsideration of that report.

Is there discussion?

L. W. GERSTNER, M.D. (Kalamazoo): May we hear from the Chairman of that Committee again?

THE SPEAKER: In the meantime, you have the floor, Dr. Novy.

R. L. NOVY, M.D. (Wayne): I simply rise for information. I was on that Committee. There was no explanation available, and it seemed proper that the fee be changed as it was.

I still heard no explanation that was given. In the public relations program of this last year, how much was spent? In the public relations program that is ahead, how much is the budget to be proposed? You say how much you want in the way of fees. I would like to have some figures on it.

Furthermore, how much has your reserve increased in the last year, including the repayment of loan made by Michigan Medical Service?

THE SPEAKER: The Chair would ask Dr. Witwer, the Chairman of the Finance Committee, to answer that, if he cares to.

E. R. WITWER, M.D.: I haven't the figures with me, Mr. Chairman.

THE SPEAKER: Dr. Foster, could you answer that approximately, offhand?

THE SECRETARY: I can't give you the figures. I believe commitments were made for practically the whole assessment. Commitments were made on annual budget, and I believe by the time the year will have ended in September, that whole fund will be depleted on the commitments already made.

THE SPEAKER: Does that satisfy you, Dr. Novy?

R. L. NOVY, M.D.: No. I asked what the reserves were and how much they had increased during last year, and there was no answer to that.

THE SPEAKER: The question has been asked about the reserves and the proposed budget. Dr. Foster is unable to answer those things offhand. Mr. Burns, have you those figures with you?

THE EXECUTIVE SECRETARY: I will get them.

THE SPEAKER: Thank you. In the meantime, Dr. Gerstner has asked Dr. DeTar to comment on this, if he can. Is Dr. DeTar here? Apparently he is not.

R. L. NOVY, M.D. (Wayne): May I ask if the reserves include bonds?

THE SPEAKER: The answer is "no" according to our Secretary.

R. L. NOVY, M.D.: How much have we got in bonds?

THE SECRETARY: \$48,283.25.

THE SPEAKER: Is there further discussion?

(Calls for the question.)

THE SPEAKER: The motion is to reconsider. Unless there is further discussion, all in favor say "aye"; opposed. It is carried. Now the Chair will entertain a motion such as there be to act on the problem.

R. V. WALKER, M.D. (Wayne): I was out of the room when apparently you passed a resolution reducing the assessment from \$25 to \$10. Had I been here, I would have voiced an objection to it. You men all invested a lot of money in your education some years ago. You have had an investment in your practice. Why don't you want to protect it? What better way is there to protect it than to have some available money to use in a proper way under the direction of the Council along the lines of these motions passed this morning?

What if we do have some reserves? None of you men spends your last nickel before you go out to spend more money to carry on your current expenses. You all try to build up a reserve. A big organization like this should have an ample amount of

reserves not to be spent on current expenses. We don't know what the future is going to be. Let's keep that reserve and be damned glad we have it.

I move that we levy an assessment not of \$25, not of \$50—make it \$75. There isn't a single one of you men here in this room who doesn't spend that much playing golf every year or shooting craps. You can shoot craps and spend \$100 in a night and not think of it. You have done it, and so have I. What is \$75 when you are paying that for insurance?

The gentleman here says, "Make it \$25." I don't think we should make it \$25. Make it \$75, and make it worth while.

Don't you have faith in your Council? They won't spend it needlessly. If you haven't faith in them, you shouldn't have that Council. You should have some other men.

I don't want to spend \$75 any more than any of the rest of you. I have to earn everything I get. But I am willing to give the Council available money to carry on the project we have so gladly passed through today.

THE SPEAKER: There is no second to the motion.

C. L. CANDLER, M.D. (Wayne): I move that the House of Delegates adopt the original resolution for the twenty-five-dollar assessment.

THE SPEAKER: It has been moved to adopt the original resolution.

G. L. MCCLELLAN, M.D. (Wayne): I second the motion.

THE SPEAKER: Is there further discussion?

W. B. HARM, M.D. (Wayne): On behalf of the Resolutions Committee, I want you all to know that this resolution was tossed into that Committee without any recommendation from the Council or from any officer of the Society. We knew nothing about the Council wanting this resolution passed at the twenty-five-dollar level. We were informed that the ten-dollar assessment that had been made last year had not been fully spent. It is not the fault of your Resolutions Committee.

If the Council wanted this, why didn't they say so? Is there a secret about the finances of this organization?

THE SPEAKER: Dr. Harm, the first part of your talk is well taken. I would like to comment on that, if I may. There were so many resolutions this time, important resolutions, that it was practically impossible for each one to be followed in the Resolutions Committee. I think Dr. Harm has made a very good point. It is unfortunate.

R. L. NOVY, M.D.: I was on that Committee, and I entirely endorse what Dr. Harm said, but I still am anxious to know how much was spent and how much was left of that assessment there last year and what the exact proposal is this year.

E. F. SLADEK, M.D. (Chairman of the Council): The final paragraph of the last recommendation of the Supplemental Report of the Council, is as follows:

"The Council recommends that the House of Delegates give serious consideration to the vital need for an increased public educational campaign, aimed to prove that the best medical care for all the people is available only through voluntary methods, and it also recommends that the House of Delegates consider ways and means of properly financing this important and necessary project for 1946."

W. J. SMITH, M.D. (Wexford): If we passed a twenty-five-dollar assessment, what would be the total dues, including the assessment, per year?

THE SPEAKER: I will ask the Secretary to answer that for you.

THE SECRETARY: There has been no change in the dues which are stipulated and set at \$12 a year. It will be \$25 plus \$12, or \$37.

I have a brief statement of our assets that our office force ran off, which will give you some idea of the status of the accounts at the present time. Please recall, however, that the fiscal year of the Society is from January to January. The House of Delegates year runs from September to next year at this time, but The Council, at its annual meeting in January, makes up the budget for the year. So at this time we are operating on the last quarter of the 1945 budget.

The cash on hand in our commercial account, as of September 15, is \$19,971.37, which may be inadequate to run the general account for the balance of this year.

The savings account, \$53,131.82, includes \$20,767.14, the unspent balance in the Public Education Account, as well as \$16,723.75, the amount held in trust for the Medical Veterans' Readjustment Program; the net savings or reserve, therefore, is only \$15,640.93.

The Medical Veterans' Readjustment Program money, \$16,723.75, is held in trust in savings accounts, and is earmarked.

The balance of \$20,767.14 in the Public Education Account is unspent at the present time, but is already allocated for a continuation of the existing activities.

The Treasurer reports that the bonds amount to \$48,283.25, including the reimbursement from Michigan Medical Service.

THE SPEAKER: Is there further discussion?

G. L. MCCLELLAN, M.D. (Wayne): I think a very important point was brought before us tonight. There are 3,300 members practicing in Michigan and paying dues, and approximately 1,200 men in the service. That means that the 3,300 members here are, in addition to their own income, taking the income of probably most of these men in the service, and out of that income you are asked to contribute \$10 more in 1946 than this year's assessments.

I do not think there is a man in the state of Michigan whose income has not been increased immeasurably by the fact that some of his confreres are serving all over the globe. If we cannot afford to make a contribution of a few dollars to save the practice of medicine for them, not out of our own pocket but out of the income that is accruing to us because they are absent, we shouldn't be in the practice of medicine.

THE SPEAKER: You have heard the question. All in favor of the motion say "aye"; opposed. The motion is carried.

HENRY COOK, M.D. (Genesee): I would like to make a request. As soon as we get home, we have to justify some of this increase. Last year when I made the report to our Society, I had to rack my brains to try to figure out exactly all that happened in that session. If we could have in some way communicated to us, before our next meeting of our societies, the principal actions of this session plus reasons why this assessment is really needed, just briefly, before the minutes of the session are printed in the JOURNAL, I think we can do a much better job of explaining to the profession what this raise in dues really contemplates doing, and I think it would help to sell and help to get the payment of dues in much better than if we just, each one of us, kind of guess at what we jotted down here when we get back.

G. L. McCLELLAN, M.D.: I move that a financial report, together with the statement of what these funds are being used for, as of today, be sent to every county society.

R. L. WADE, M.D. (Branch): I second the motion.

VOLNEY BUTLER, M.D. (Wayne): I amend the motion to the effect that a copy of this be sent to each member of the House of Delegates.

THE SPEAKER: Is there a second to Dr. Butler's amendment?

R. L. WADE, M.D. (Branch): I second the motion.

THE SPEAKER: Is there discussion on Dr. Butler's amendment, that a copy of this report be sent to each delegate?

All in favor of the amendment say "aye"; opposed. Will the "ayes" please rise. Thank you. The "noes." The motion is carried.

Now on the main motion—that the report of the finances and an explanation of what the finances are being used for be sent to every county society, and with the amendment that it would go to every member of the House of Delegates. Is there discussion?

E. R. WITWER, M.D.: I wonder whether you gentlemen realize exactly the implications of the motion, as I see it. I may be wrong.

What you are demanding of your Council, whom you elect to carry on your financial activities throughout the year, is an accounting that you get every year in the JOURNAL. Your financial statement is published in detail in the JOURNAL of the Michigan State Medical Society.

I do not dispute the right of any member of the House of Delegates to know what the financial status of the Society is. That is your privilege, but you are throwing on an already over-worked executive office a tremendous burden.

It has not been stipulated how often you want this report. Do you want it once, twice, three times, or four times a year? The Council meets in executive session four times a year, and the finances of the Society, I can assure you, are adequately combed at that time. You have a very able watchdog of the treasury in Dr. Hyland, who, I am sure, is willing and ready to explain any financial items that are questioned.

If you feel that you want to know all those details—and they are details I can assure you—and you want the executive office to have that additional burden, very well and good. That is your privilege. But I felt that you should know what you are voting on.

L. W. GERSTNER, M.D. (Kalamazoo): I had risen to say about the same thing that was said, in a different way. The motion that is on the floor may supply the data we wish. I would be more in favor of a friendly letter from our Executive Secretary, in his subtle way, telling the delegates the reason for the need of such assessment of \$25, that we could present to our county societies. I don't think we need a whole financial statement. I believe that if Dr. Foster would write a letter to us, detailing briefly the need, our county societies would accept it willingly.

(The Vice Speaker took the chair.)

G. L. McCLELLAN, M.D. (Wayne): I made the motion in response to a demand by the delegate, to strengthen his hand when he reported to his home city. I think he and every other delegate is entitled to that consideration.

I would call attention to the fact that the motion incorporated the clause "as of today." That means only a single report. It means only a mimeographed copy of the report which was read by the Secretary. That is all it means, with a little note of explanation, what this is being done for, how it is being expended, and it will entail no great problem whatever to the office force.

If you don't feel that you want the delegates and the county societies to know all about this, that is perfectly all right. The only intent of the motion was to take the heat off the delegate who felt he had to go home and explain something.

R. C. PERKINS, M.D. (Bay): May I suggest that you place on that letter the last paragraph which Dr. Slade read, which comes from the Council of the Michigan State Medical Society, who were duly elected to carry on that sort of thing? That is explanation enough, in my opinion.

E. R. WITWER, M.D.: Mr. Speaker, in considering this whole matter, I wonder how many of the Delegates, if they got this financial report, would keep it where it belongs. In other words, I wonder if they would keep it where it is not accessible to their office help or to members of other organizations who might be interested in knowing what the Michigan State Medical Society is doing in that regard.

Secondly, you have representation through your councillors, in every district in the state of Michigan, and any delegate who does not get the information that he wants is entirely justified in registering a complaint or making a request to his Councillor. When that request is received, I am sure there is not a single member of The Council of this Society who would not be very happy to explain it to your delegates in detail.

THE SPEAKER: Any further discussion?

J. M. ROBB, M.D. (Wayne): I agree with Dr. Witwer, that a too generous spread of information doesn't do one much good. I believe also that with that statement there should be sent a

statement of the fact that about one-third of the members of the Society are at war, and that this burden and therefore the necessary increase is partly due to such a situation.

P. H. ENGLE, M.D. (Eaton): I wonder if we have not missed the entire intent of our original suggestion. I want to present to my own county society a résumé of the projected program for next year. Isn't that enough?

THE VICE SPEAKER: I think that was the intent of the original motion.

S. W. INSLEY, M.D. (Wayne): I would like to refer the delegates to their Handbooks, on page 32, second paragraph, which reads:

"The over-all picture of cash on hand, total available cash, stocks, investments, war bonds, and foundation funds, is a decidedly healthy one; this is attested to again by the Ernst & Ernst report. If he so desires, any interested member is urged to make a detailed study at the MSMS headquarters, 2020 Olds Tower, Lansing, Michigan."

THE VICE SPEAKER: Any further discussion? If not, are you ready to vote on the question?

VOICE: What is the question?

THE VICE SPEAKER: Dr. McClellan, will you repeat your motion?

G. L. McCLELLAN, M.D. (Wayne): I will repeat it for the third time.

The question was raised that some of the men had to go back home and explain to their constituency why they voted for this raise. I made the motion that a financial report, such as the one that was introduced to us a few minutes ago by Mr. Burns, be sent to every county society with the explanation of what the proposed assessment will be used for.

Dr. Butler introduced an amendment to it, that included in the list of the mailing, the delegates.

THE VICE SPEAKER: We are voting on the original motion. All in favor respond by saying "aye"; contrary, "no." The "ayes" will please rise. Will the "noes" rise? The motion is lost 32 to 40.

(The Speaker resumed the chair.)

X. Chippewa-Mackinac County Medical Society Matter

SPEAKER: The next item of business is the Chippewa-Mackinac County Medical Society matter. This will be carried out according to Chapter 1, Section 2 of the By-Laws. This is a question of revocation of a county medical society charter.

Thereupon, the House of Delegates held a hearing upon the petition for the revocation of the charter of the Chippewa-Mackinac County Medical Society, listening to and weighing all the evidence presented. After a thorough study of the matter, the House decided not to approve the petition that the Charter of the County Medical Society be revoked, by a vote of 44 to 37.

XI. Elections

XI-1. COUNCILOR—2ND DISTRICT

THE SPEAKER: Now we have election of officers. The first is Councilor for the Second District. Philip A. Riley, M.D., is the incumbent. Nominations are in order.

L. G. CHRISTIAN, M.D. (Ingham): The delegates of Hillsdale, Eaton, Jackson and Ingham counties met today and unanimously nominated Philip A. Riley to succeed himself.

THE SPEAKER: Dr. Riley is nominated. Are there other nominations?

J. J. O'MEARA, M.D. (Jackson): I move the nominations be closed and the Secretary be instructed to cast the ballot for Dr. Riley.

(The motion was seconded by R. S. Breakey, M.D., Wayne, and carried. The Secretary did so cast.)

XI-2. COUNCILOR—3RD DISTRICT

THE SPEAKER: The next is Councilor for the Third District; Wilfrid Haughey, M.D. of Battle Creek, is incumbent.

A. T. HAFFORD, M.D. (Calhoun): Speaking for the Third District, I nominate Dr. Haughey to succeed himself as Councilor of the Third District.

THE SPEAKER: Dr. Haughey has been nominated. Are there other nominations?

R. A. SPRINGER, M.D. (St. Joseph): I move the nominations be closed and the unanimous ballot be cast.

(The motion was seconded by R. A. Johnson, M.D., Wayne, and carried. The Secretary did so cast.)

XI-3. COUNCILOR—15TH DISTRICT

THE SPEAKER: Next is Councilor of the Fifteenth District, O. O. Beck, M.D. of Birmingham, the incumbent.

J. S. LAMBIE, M.D. (Oakland): Speaking for the Fifteenth District, I nominate Dr. O. O. Beck.

THE SPEAKER: Dr. O. O. Beck has been nominated. Are there other nominations?

R. C. PERKINS, M.D. (Bay): I move the nominations be closed and the Secretary be instructed to cast the ballot.

(The motion was seconded and carried. The Secretary did so cast.)

XI-4. COUNCILOR-16TH DISTRICT

THE SPEAKER: The next is the Councilor for the Sixteenth District, *E. R. Witwer* of Detroit, the incumbent.

C. F. BRUNK, M.D. (Wayne): Speaking for the Sixteenth District, I wish to nominate *E. R. Witwer* to succeed himself.

S. W. INSLEY, M.D. (Wayne): I move that the nominations close and the Secretary be instructed to cast the unanimous ballot.

(The motion was seconded and carried. The Secretary did so cast.)

XI-5. DELEGATES TO AMA

THE SPEAKER: The next are delegates to the American Medical Association.

May I explain that there are two delegates to be nominated. The By-laws require that there shall be at least two delegates nominated.

G. L. McClellan, M.D. (Wayne): I would like to place in nomination a man who has served the organization very well and faithfully, *Dr. L. G. Christian*.

A. V. WENGER, M.D. (Kent): I second the nomination.

R. A. JOHNSON, M.D. (Wayne): I would like to place in nomination a man who is well known to you all, *F. E. Reeder* of Flint.

THE SPEAKER: *Dr. Frank Reeder* of Flint has been nominated to succeed himself. Are there other nominations?

T. K. GRUBER, M.D. (Wayne): I move that the nominations be closed, and that the Secretary be instructed to cast the ballot of the organization.

(The motion was seconded by C. R. Keyport, M.D., and carried. The Secretary did so cast.)

XI-6. ALTERNATE DELEGATES TO AMA

THE SPEAKER: Next are nominations of Alternate Delegates. In nominating alternate delegates, we have to be a little bit careful, because their seniority is determined by the number of votes, so after we have the nominees, if you wish to vote by ballot, however you wish, that is all right. Sometimes it is done that way. Sometimes it is done in other ways, but seniority has to be established.

We are ready for nominations of Alternate Delegates. *R. H. Pino* of Detroit and *H. H. Cummings* of Ann Arbor are the incumbents.

R. V. WALKER, M.D. (Wayne): Mr. Speaker, I would like to nominate as Alternate Delegate to the AMA, a man whose interest in the Society has been manifest many times. I would like to nominate *Dr. Pino* to succeed himself.

THE SPEAKER: *Dr. Ralph Pino* has been placed in nomination. Are there other nominations? We have to have at least two.

J. J. O'MEARA, M.D. (Jackson): I would like to nominate *Dr. Howard H. Cummings* to succeed himself.

THE SPEAKER: *Dr. Howard H. Cummings* has been nominated.

THE SPEAKER: We have to vote by ballot unless you suggest some other way of determining seniority.

R. A. JOHNSON, M.D. (Wayne): I move that seniority be determined by placing the names on slips of paper and that the first name drawn out of the hat will have seniority.

THE SPEAKER: Is there a second to that?

J. J. O'MEARA, M.D. (Jackson): I second it.

THE SPEAKER: You understand you vote for both members, unanimous vote. Seniority only will be determined by drawing from the hat.

(The motion was carried.)

R. A. SPRINGER, M.D. (St. Joseph): I move the nominations be closed and the Secretary cast the unanimous ballot.

(The motion was seconded by T. G. Amos, M.D., of Wayne, and carried.)

THE SPEAKER: The Secretary is also instructed to prepare the slips. The Chair will appoint *Dr. Harold Morris* to draw the slips.

(Drawing from the hat)

THE SECRETARY: *Dr. Cummings*.

THE SPEAKER: *Dr. H. H. Cummings* is the senior Alternate Delegate and *Dr. R. H. Pino* is the Junior Alternate Delegate.

XI-7. PRESIDENT

Next is the nomination for President. You all understand there is an unusual circumstance this year, in that we lost our dear President, *Vernor M. Moore*, M.D. I would like to suggest at this time that we stand just one moment in memory of *Dr. Moore*.

(The audience rose and stood for one minute in silent tribute to the memory of *Dr. Moore*.)

R. S. BREakey, M.D. (Ingham): Ingham County had hoped to place before this group the name of a candidate for the presidency for the ensuing year. It has been forty-six years since a member of that County Medical Society has held office in the State Society.

It is my privilege, however, to subject whatever sense of priority we might feel in the nomination of a man from an adjacent district, with whom we have all become acquainted and for whom personally I have the greatest admiration.

He has been honored by his own society by election first as secretary, and then as president. He served on the first Maternal Welfare Committee of the Michigan State Medical Society. He has been Chairman of the Flint Red Cross since 1939. For nineteen years he has served as administrator of the Veterans' Administration for the Genesee County area. For six years we in the House have elected him to The Council, and he has served on the Executive Committee two years.

He has been Chairman of the Publication Committee, and very important, he is chairman of the MSMS Committee on Medical Veterans' Readjustment Program, the matter which we have discussed at some length at this session.

I should like personally to add much to my own feeling concerning *Dr. Morrish*. I should have liked to have known him long. I have never met a man here or in medicine, in my opinion, of higher integrity. I certainly hope that most of you will agree with my sentiment and endorse this nomination of *Dr. Ray S. Morrish*.

THE SPEAKER: *Dr. Ray Morrish* has been nominated.

THE SPEAKER: Are there other nominations?

HENRY COOK, M.D. (Genesee): I just wanted to second the nomination of *Dr. Morrish*. We were very happy to extend the courtesy to them, as well as to receive the courtesy of the nomination of our man from Genesee County.

We respect and love *Ray* very much, and we think he has what it takes.

R. V. WALKER, M.D.: I second the nomination and move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for *Dr. Morrish*.

(The motion was seconded by C. R. Keyport, M.D., and carried. The Secretary did so cast.)

THE SPEAKER: Your Speaker at this time would like to say "amen" to all the nice things that have been said about *Ray Morrish* and add some of his own.

The next duty then is to ask the various and sundry and distinguished Past Presidents to escort President *Ray S. Morrish* up here. Will the Past Presidents of the Society act as an escort?

President *Morrish* expressed gratitude to the delegates, and requested their help during his tenure of office.

XI-8. PRESIDENT-ELECT

The next order of business, then, is the nomination of the President-elect. Nominations are in order for the office of President-elect.

J. M. ROBB, M.D. (Wayne): I should like to place in nomination a friend of mine, since I was president-elect of the Society myself in 1932. He has been financial man of this Society through these years, and I presume the reason they put him in was because when I became president-elect they knew that in order to see that the matter was properly adjusted and carried on, they had to have somebody watch it closely.

He is a handsome man, too. He is not as handsome now as he was thirteen years ago, but neither am I, but I am glad to present myself to show that I don't look like that picture that was on the STATE JOURNAL cover.

Dr. William Hyland wants to continue his duty with the Society, and I think that no one deserves that consideration more than he does. It gives me the greatest pleasure to present the name of *Dr. William Hyland* as President-elect of this Society.

THE SPEAKER: *Dr. William A. Hyland* has been nominated. Are there other nominations?

L. E. SEVEY, M.D. (Kent): I would like very much to second the nomination of *Dr. Hyland*, who is from my own county. I have known *Dr. Hyland* for thirty years. He has been interested in organized medicine. He has served his County Society for many years and is the Past President of the Kent County Medical Society. I know he will serve this organization well.

Again it gives me pleasure to second his nomination.

F. J. O'DONNELL, M.D.: I have known *Dr. Bill Hyland* since I was three years old, and he has known me since I was three years old, and it gives me great pleasure to stand here and support his nomination for president-elect. We grew up together. He has always been a good financier and leader. So, as I said before, I appreciate the privilege of supporting his nomination for President-Elect.

R. A. JOHNSON, M.D.: I move the nominations be closed and the Secretary be instructed to cast the unanimous ballot for *Dr. Hyland* as President-Elect.

(The motion was seconded by W. J. Smith, M.D., Wexford, and carried. The Secretary did so cast.)

THE SPEAKER: *Dr. Hyland* is elected.

Now the Past Presidents will officiate once more and escort President *Wm. H. Hyland* to the rostrum.

XI-9. COUNCILOR-6TH DISTRICT

Electing *Dr. Morrish* for President makes vacant the position he holds as Councilor for District No. 6. Are the members of that Councilor District ready to make the nomination now for that Councilor District?

C. L. WESTON, M.D. (Shiawassee): The Sixth District would like to place the name of *Dr. R. C. Pochert* of Owosso in nomination for Councilor.

A. H. KRETCHMAR, M.D. (Genesee): I second the nomination. W. B. McWILLIAMS, M.D. (Clinton): I want to second the nomination.

THE SPEAKER: Are there other nominations?

W. B. McWILLIAMS, M.D. (Clinton): I move the nominations be closed and the Secretary be instructed to cast the ballot.

(The motion was seconded by Volney Butler, M.D., of Wayne, and carried. The Secretary did so cast.)

XI-10. SPEAKER OF HOUSE OF DELEGATES

THE SPEAKER: The next item of business is the election of the Speaker of the House. Nominations are now in order, and I will ask *Dr. Oakes* to take the chair.

(E. A. Oakes, M.D., the Vice Speaker, took the chair.)

(Continued on Page 1380)

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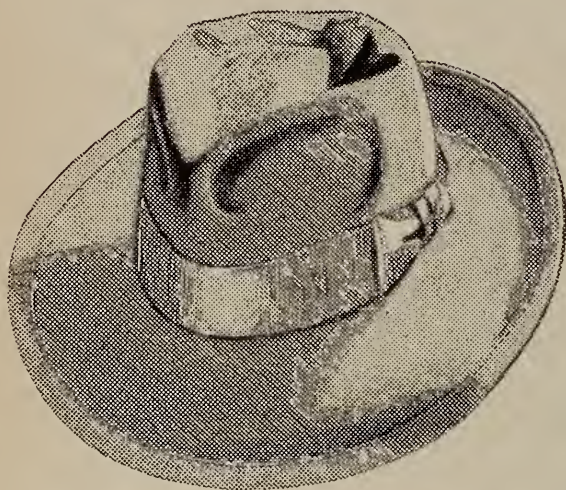
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(Continued from Page 1378)

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VOLNEY BUTLER, M.D. (Wayne): I think we have had a very good Speaker of the House in the last few years. I wish to nominate Dr. P. L. Ledwidge to succeed himself.

THE VICE SPEAKER: Are there other nominations?

J. M. ROBB, M.D. (Wayne): I second the nomination.

J. J. O'MEARA, M.D. (Jackson): I move the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. Ledwidge as Speaker.

(The motion was seconded and carried. The Secretary did so cast.)

THE VICE SPEAKER: Dr. P. L. Ledwidge is re-elected Speaker. (P. L. Ledwidge, M.D., the Speaker, resumed the chair).

XI—11. VICE SPEAKER OF HOUSE OF DELEGATES

THE SPEAKER: The next matter of business is the election of a Vice Speaker for the House. Nominations are now in order.

R. V. WALKER, M.D. (Wayne): I would like, without any further ado, to nominate Dr. E. A. Oakes to succeed himself as Vice Speaker.

THE SPEAKER: Dr. E. A. Oakes has been nominated to succeed himself.

THE VICE SPEAKER: I am sorry. I would rather withdraw for several reasons. I could go on at great length, but it is impossible for me to do it, and I would like to be relieved. Thank you for your expression.

THE SPEAKER: Dr. Oakes, we regret your declining.

Are there other nominations for Vice Speaker of the House?

HENRY COOK, M.D. (Genesee): I would like to nominate Dr. J. S. DeTar, who was the Chairman of the Resolutions Committee. I think he conducted himself very well.

THE SPEAKER: Dr. DeTar of Washtenaw County has been nominated.

J. M. ROBB, M.D. (Wayne): I second the nomination.

THE SPEAKER: Are there other nominations?

C. R. KEYPORT, M.D.: I move the nominations be closed and the unanimous ballot be cast for Dr. DeTar.

(The motion was seconded and carried. The Secretary did so cast.)

THE SPEAKER: Dr. J. S. DeTar is elected Vice Speaker.

That, gentlemen, completes the official business. I would like to take just one moment to thank the House of Delegates, first, for re-electing me. It is nice, after all my mistakes, to know that I still have the confidence of the House. I thank you very, very much.

At the same time, I want to thank all those who have helped make this meeting a success. That means every delegate who has come. It means everybody who worked on committees, and all those who have had anything to do with it.

I cannot let another year go by without expressing once more the appreciation of the work that was done in our executive office and by our Secretary, Executive Secretary, and all the office force. There is a tremendous amount of work that goes through there, and if it were not for their help, The Council could never do it.

With that, it is now my privilege to turn the meeting over to President Brunk.

XII. President's Address and Induction of New President

President Brunk delivered the President's Annual Address. After the address, the retiring President introduced R. S. Morrish, M.D., Flint, as the incoming President of the Michigan State Medical Society and presented to him the President's Medal as the symbol of his office, signifying his induction into the presidency.

President Morrish responded, thanking the Delegates for their confidence, requesting their continued support, and pledging his very best efforts to continue the leadership of the Michigan State Medical Society during the ensuing year.

Dr. Brunk then introduced Wm. A. Hyland, M.D., Grand Rapids, the new President-elect, as well as the newly elected Councilors, Philip A. Riley, M.D., Jackson, 2nd District; Wilfrid Haughey, M.D., Battle Creek, 3rd District; O. O. Beck, M.D., Birmingham, 15th District; E. R. Witwer, M.D., Detroit, 16th District; and R. C. Pochert, M.D., Owosso, 6th District. Also the newly elected Delegates to the American Medical Association; L. G. Christian, M.D., Lansing, and F. E. Reeder, M.D., Flint; and the Alternate Delegates to the AMA: H. H. Cummings, M.D., Ann Arbor, and R. H. Pino, M.D., Detroit.

Dr. Brunk also introduced P. L. Ledwidge, M.D., Detroit, Speaker of the House of Delegates, and John S. DeTar, M.D., Milan, Vice Speaker of the House of Delegates.

The retiring President introduced the Chairman of The Council, E. F. Sladek, M.D., Traverse City.

Dr. Sladek presented to retiring President Brunk the Past President's Key and a scroll indicating the appreciation of the medical profession of Michigan to Dr. Brunk for his accomplishments of the past year and his long-time service to Medicine.

XIII. ADJOURNMENT

J. M. ROBB, M.D. (Wayne): I move we adjourn.

(The motion was seconded and carried, and the House of Delegates adjourned at two-forty o'clock, A. M.)

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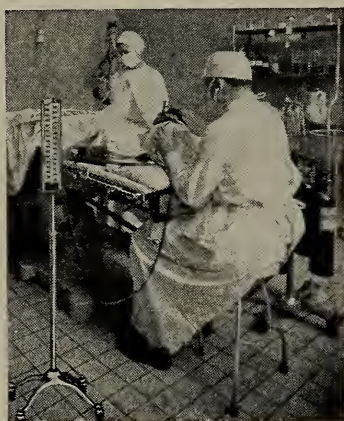
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Woman's Auxiliary

HOLIDAY GREETINGS

This holiday season should be one of the happiest we have ever known. Peace once more is on the earth and our future endeavors should be toward good will for all.



The Auxiliary's efforts during the war have been productive; but, let us not slacken our efforts in the future. Let us all work together to help build a brave new world on the foundation of a lasting peace, that all men everywhere may breathe again as free men; that suffering and oppression may vanish forever from the earth; that the labor of all men

may be devoted to the good of mankind; that all may live in health and peace forever!

Your officers and committee chairmen join with me in wishing you a very Merry Christmas and a most successful New Year.

DELL HARVIE, *President.*

COMMITTEE CHAIRMEN

Program—Mrs. W. L. Sherman, 201 E. Kirby Ave., Detroit 2.

Public Relations—Mrs. L. A. Campbell, 335 Brockway Pl., Saginaw.

Finance—Mrs. Wm. J. Butler, 327 Briarwood, S.E., Grand Rapids.

Legislation—Mrs. Sherman Andrews, 2326 Springhill Dr., Kalamazoo.

Organization—Mrs. Oscar D. Stryker, 115 Division Ave., Fremont.

Press—Mrs. A. D. Allen, 2309 Nurmi Dr., Bay City.

Bulletin—Mrs. Homer A. Ramsdell, 514 Oak St., Manistee.

Archives—Mrs. L. G. Christian, 400 Everett Dr., Lansing.

Historian—Mrs. J. Earl McIntyre, 600 S. Grand Ave., Lansing.

Parliamentarian—Mrs. Glen C. Hicks, 1009 Wildwood Ave., Jackson.

Hygeia—Mrs. D. M. Kane, Sturgis.

Radio Speech Project—Mrs. Milton Shaw, 415 West St., Lansing.

Revision—Mrs. Alfred LaBine, 1019 College Ave., Houghton.

War Service—Mrs. Galen B. Ohmart, 374 Lodge Dr., Detroit 14.

Student Loan Fund—Mrs. Roger Walker, 1507 Iroquois Ave., Detroit 14.

Nominating—Mrs. G. L. Willoughby, 5013 No. Saginaw St., Flint.

PRESIDENT'S MESSAGE

Presented at the 1945 Convention of the Woman's Auxiliary, Detroit, September 17-18, 1945

With a feeling of deep gratitude and indebtedness to my predecessors in office, I assume the leadership of this organization. I deeply appreciate the honor of being your president and wish to thank you for your faith and confidence in me; and it is my earnest hope that I may merit the honor, prove worthy of your confidence, measure up to your expectations, have courage to do all in my power to meet the many emergencies that are bound to arise and trust that we may, as an auxiliary, fulfill our obligations as an "aid to the medical profession."

We are thankful for the opportunity of meeting once more with the world at peace. Our sincere sympathies are extended to our members who have felt the tragic loss of war and we rejoice with those whose loved ones have returned safely home.

As we enter upon another year of our organization, we are confronted with grave situations which may have far-reaching consequences with respect to the ideals and basic rights of American Medicine. We must promote vigorously the objectives for which we stand as an auxiliary to the Michigan State Medical Society. We, no doubt, will be called upon to aid the profession in its fight against socialization schemes that masquerade under colors of humanitarianism. As our National President has said, "All the laws and Bureaucratic decrees in the world will not give the nation first-class medical service. Only the doctors can do that; and only when there is opportunity for individual progress and achievement."

Our auxiliaries can make no finer contribution to their medical societies than to acquaint the public with the advance of medicine and health education; continue the promotion of *Hygeia*, our official health publication; encourage improvement in public relations between organized medicine and the laity; co-operate with other organizations in juvenile delinquency programs; support the medical profession in its Physical Fitness program and assist in the re-establishment program for returning doctors and their families.

At no time since becoming active in this society has your president felt such appreciation; at no time has she been so humble as she reviewed the outstanding work of those holding this office before her. Never has she been more anxious to live up to the expectations of this membership or to assume the responsibilities of carrying on in a way that would be a credit to the Auxiliary. So, she asks for the quiet tactfulness, the thoroughness and efficiency, the wit and sparkle, the sweet, calm graciousness, the friendly at-homeness, the

(Continued on Page 1384)

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(Continued from Page 1382)

courage and perseverance of our past presidents. And, with our honorary president's excellent counsel and assurance—perhaps, if she can acquire at least a few of these attributes, she will be able to carry on acceptably with the help of the splendid board members you have elected to service, the standing committee chairmen, the county presidents and each and every member.

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With the tools of today—
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(MRS. LLOYD C.) DELL HARVIE, *President.*

Correspondence

Dear Doctor Foster:

I have received your letter this date, telling me of the high honor bestowed upon me, by being placed in the Retired Membership in the Michigan State Medical Society. I thank you and the Society very much for this honor; I also appreciate your encouraging and charming letter. Thanking you again, I am

Most cordially yours,

J. W. GORDON, M.D., Detroit.

November 7, 1945.

Dear Doctor Foster:

I received your very kind letter of the fifteenth of this month and I take this opportunity to thank you for your courtesy. I believe this is one of the pleasant memories I will have to look back on in the year to come. I would like to thank personally every one who had a part in this honor for me. I have a son teaching Internal Medicine in Harvard University and I am sure he too will appreciate the honor you have conferred on me.

Very sincerely,

W. EARLE CHAPMAN, M.D.

Cheboygan

November 15, 1945

Dear Doctor Foster:

I received your letter notifying me of the honor conferred by the House of Delegates and I assure you I am appreciative.

Beginning practice in 1898, I feel that I have lived in the Golden Age of medicine and surgery and have been fortunate to so do. No other period in history has shown such amazing advancement in the treatment of the sick, and I feel proud to have been identified with it.

I am still in active practice, although seventy years old, and while of necessity it can not be long, I hope to remain active until the end.

Sincerely yours,

E. T. MORRIS, M.D.

Nashville

November 20, 1945



Yes—we have no pana-C-eas

Needless to tell you, Doctor, vitamin C is *not* a cure-all. But—recent literature is replete with reports of good results obtained from massive doses of vitamin C in various allergies, particularly hay fever; in convalescence; in infectious diseases and toxic conditions; in some cases of gingivitis and pyorrhea; and in many other conditions due to vitamin C deficiencies.

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* * *

E. S. Gurdjian, M.D., and L. W. Walker, M.D., Detroit, are authors of an original article "Traumatic Vaso-pastic Disease" which appeared in JAMA of November 3, 1945.

* * *

"Physicians Separated from Service" is and has been a regular feature of JAMA for several months. Each week, a list of newly separated medical veterans, indicated by states, is published in JAMA.

* * *

Vicksburg, Michigan, will honor the deeds and memory of Charles E. Osborne, M.D., physician and surgeon of that city who was killed in 1944 while aboard a Jap prison ship, by equipping a "Dr. C. E. Osborne Memorial Nursery" at Franklin Memorial Hospital in Vicksburg.

Basic Sciences Examination

The Board of Examiners in Basic Sciences conducted a special examination for Michigan and for out-of-state applicants on Friday and Saturday, December 28 and 29, 1945 at Wayne University College of Liberal Arts, Detroit.

* * *

Alexander W. Blain, III, M.D., Detroit, who received his M.D. from the Wayne University College of Medicine, March 4, 1943, was recently appointed a William Halstead Fellow in Surgery at Johns Hopkins University and Hospital.

* * *

Wholesale exodus for P.G. work. Twenty-seven members of Detroit's Mount Carmel Mercy Hospital staff were absent during parts of October-November taking postgraduate courses in Boston, New York, and New Orleans.

* * *

B. R. Shurly, M.D., member of the Detroit Board of Education, was the medical representative on a

(Continued on Page 1388)

Michigan State Medical Society ANNUAL COUNTY SECRETARIES CONFERENCE Sunday, January 20, 1946 Wardell-Sheraton Hotel, Detroit

PROGRAM

1. 10:00 to 10:20 a.m. Progress report on Michigan Medical Service.....
R. L. Novy, M.D., Detroit
2. 10:40 to 12:00 noon Tour of Michigan Medical Service Headquarters
3. 12:20 to 1:15 p.m. Noonday dinner, Wardell-Sheraton Hotel, Detroit
4. 1:15 to 2:00 p.m. Veterans' Administration Plans.....Col. J. C. Harding, MC,
representing Maj. Gen Paul R. Hawley, Washington, D. C.
5. 2:00 to 2:20 p.m. Uniform Fee Schedule for Governmental Agencies.....
G. L. McClellan, M.D., Detroit
6. 2:20 to 2:40 p.m. Michigan Foundation for Medical and Health Education.....
E. I. Carr, M.D., Lansing
7. 2:40 to 3:00 p.m. Postgraduate Medical Education.....
Maj. Gen. George F. Lull, Washington, D. C.
8. 3:00 to 3:20 p.m. Medical Public Relations.....E. J. McCormick, M.D., Toledo, Ohio
9. 3:20 to 4:30 p.m. Round Table Discussion.....Leader: S. W. Insley, M.D., Detroit

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(Continued from Page 1386)

Panel to discuss Act 70 of the Public Acts of 1945, before the Michigan Association of Welfare Boards and the Michigan Society of Mental Hygiene, at the Statler Hotel, Detroit, November 15.

* * *

The Chicago Medical Society will hold its annual clinical conference at the Palmer House, Chicago, Illinois, March 5, 6, 7, 8, 1946. All physicians are invited to attend this Conference and hear the outstanding specialists from all sections of the country discuss subjects of major interest.

* * *

The annual meeting and dinner of the Alexander Blain Hospital, Detroit, was held at the Detroit Club in Detroit on November 10. The guest speaker, Dr. Clarence C. Little of Bar Harbor, Maine, spoke on "Some Aspects of Cancer Research." One hundred fifty-seven guests were in attendance.

* * *

Captain Lowell T. Coggeshall, MC (formerly of Ann Arbor) is winner of this year's Gorgas Medal established by Wyeth, Incorporated, in memory of Major General William Crawford Gorgas and awarded annually since 1945 by the Association of Military Surgeons of the United States for outstanding work in preventive medicine for the armed forces.

Congratulations, Dr. Coggeshall!

* * *

Clark D. Brooks, M.D., Detroit, was guest speaker at the Tenth National Assembly of the United States Chapter of the International College of Surgeons, at Mayflower Hotel, Washington, D. C., December 6-7-8. Dr. Brooks spoke on "Gall-Bladder Surgery."

Herbert Acuff, M.D., Knoxville, Tenn., is President and *L. J. Garipey, M.D.*, Detroit, is Secretary of the U. S. Chapter of the International College of Surgeons.

* * *

The Fourth Councilor District held a meeting in Niles on Thursday, December 13. Brief addresses were presented by Councilors R. J. Hubbell of the Fourth, Wilfrid Haughey, M.D., of the Third, and A. B. Smith, M.D., of the Fifth. Also President R. S. Morrish, M.D., Flint, President-elect Wm. A. Hyland, M.D., Grand Rapids, Secretary L. Fernald Foster, M.D., Bay City, and Executive Secretary Burns, Lansing.

* * *

Major Herbert W. Harris, MC (Lansing) was recently awarded the Bronze Star Medal for meritorious achievement in connection with military operations. Previously he had been awarded the Cross of the Order of the Crown of Italy.

His citation commended him for his untiring zeal, high operating skill and devotion to duty in the care of bone and joint cases among the battle wounded.

* * *

"I have written personal letters in longhand to ten advertisers in *THE JOURNAL* of the Michigan State Medical Society," writes a Michigan physician sta-

(Continued on Page 1390)

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(Continued from Page 1388)

tioned with a U. S. Naval Unit in the Continental United States. "It was a pleasure to comply with your suggestion in the September MSMS JOURNAL, in return for the fine spirit shown by our Society to its members in the armed forces," states this medical veteran, who desires to remain anonymous.

Thank you, Doctor, most sincerely!

* * *

"When Bobby Goes to School," the educational-to-the-public film developed by the American Academy of Pediatrics, may be exhibited to the public by any licensed doctor of medicine, provided he obtains an endorsement from an officer of his county medical society .

This 16 mm. sound film, free from advertising, deals with the health appraisal of the school child, and may be borrowed without charge or obligation by writing the distributor, Mead Johnson & Company, Evansville, Indiana.

* * *

Volume 45 of the MSMS Journal (beginning with the January, 1946, number) will have a number of typographical improvements. Instead of "Old Style," the type used throughout will be "Baskerville."

The masthead has been changed, using new type and improvements in layout.

The most significant change will be in the cover, presenting less "gingerbread" and more of a modern treatment, with more space for illustrations. Suggestions for further improvement are invited by the MSMS Publication Committee.

* * *

The cost of the Wagner-Murray-Dingell proposal: "In making a careful study of the provisions and new proposals of the Wagner-Murray-Dingell Bill," states the *United States Review* of August 11, "Mr. Calhoun and his experts have come to a belief that a joint payroll tax of at least 12 per cent and possibly 14 to 15 per cent will be required to finance it and that provision may have to be made for substantial subsidies from the Treasury as well.

"That's too much," said one member of the Ways and Means Committee. . . . 'The country won't stand for it.'"

* * *

Mauldin Praises Medics.—In the Sunday, October 7, issue of the *Detroit Free Press*, Bill Mauldin, popular cartoonist and writer of World War II fame, states, "The medical corps probably did more to endear our army to civilians in stricken areas of Europe than the high-powered agencies which came over with that task in mind. No one will ever know how many French, Sicilian and Italian kids will go through life bearing the first name of the doctors who, in their spare time, and they needed rest badly, made deliveries in chilly stables and first-aid tents. Nobody ever hesitated to apply to our medics for aid."—*Detroit Medical News*, October 29, 1945.

(Continued on Page 1392)

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(Continued from Page 1390)

The Institute of Industrial Health and Hygiene and Nursing met November 6-7 at the Rackham Bldg., Detroit, and conducted an excellent postgraduate symposium. The Institute was under the sponsorship of the Detroit Industrial Safety Council in co-operation with the Michigan State Medical Society, Wayne County Medical Society, Michigan Association of Industrial Physicians and Surgeons, Michigan Department of Health, and the Michigan Industrial Hygiene Association, the Detroit Department of Health and the Detroit Industrial Nurses Association. Topics covered included industrial hygiene, industrial surgery, industrial health, school of public health, industrial nursing.

* * *

Extract from *Nation's Business*:

"The era of whip-lashing bureaucrats and do-it-now executive orders is definitely over."

"Said Mr. Truman at Jefferson City on February 22, 1945: 'Sound social advancement requires always time and tolerance.'"

"Study Committees may recommend that the whole security program be placed on a voluntary basis (like veterans' insurance), giving present participants privilege of withdrawing 'cash values' accrued during past ten years, and then putting each segment of the revised program on a pay-as-you-go basis." (This optimistic viewpoint seems too good to be true.—JMSMS Editor.)

(Continued on Page 1394)

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GYNECOLOGY—Two-week Intensive Course, starting February 25. One-week Personal Course in Vaginal Approach to Pelvic Surgery, starting February 18.

OBSTETRICS—Two-week Intensive Course, starting February 11.

ROENTGENOLOGY—Courses in X-ray Interpretation, Fluoroscopy, Deep X-ray Therapy available every week.

MEDICINE—Two-week Intensive Course, starting February 18.

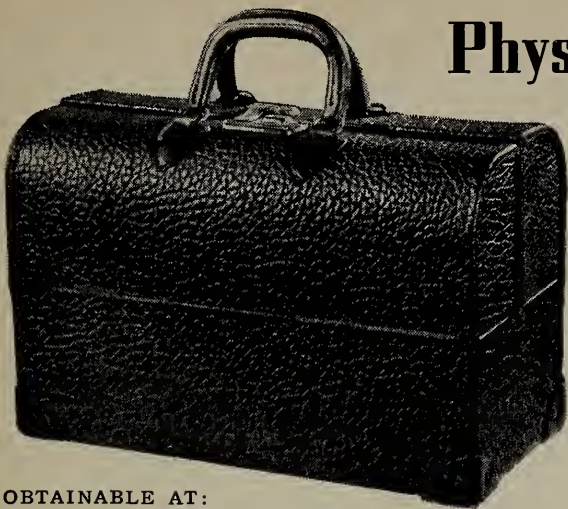
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(Continued from Page 1392)

The Wayne County Medical Society has circularized its membership with a postal card, developed by its Postwar Planning Committee, seeking the following information:

- "1. Can you share your office with a medical veteran?"
- "2. Will you be able to utilize a medical veteran as an assistant?—an Associate?—a Partner?"
- "3. Can you use a medical veteran to make calls for you?"
- "4. Is there any office space suitable for a physician for rent in your building or neighborhood?"

Vital information of valuable assistance to returning medical veterans will be the result of this pertinent inquiry.

* * *

The Bulletin of the Kent County Medical Society, November, 1945, number, published under "Reminiscences" the minutes of the first meetings of the Society 43 years ago. The first session was held Nov. 14, 1902, the organization meeting called by J. B. Whinery, M.D., a representative of the Michigan State Medical Society, "who explained it was the desire of the State Society to have formed a Kent County Medical Society to comprise all practitioners of medicine who were willing to sign a statement that they would abide by the rules and regulations of the State Society and those

(Continued on Page 1396)

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(Continued from Page 1394)

adopted by a Kent County Society—about to be formed, to practice medicine, without reference to class or party, to live up to the Code of Ethics of the American Medical Association."

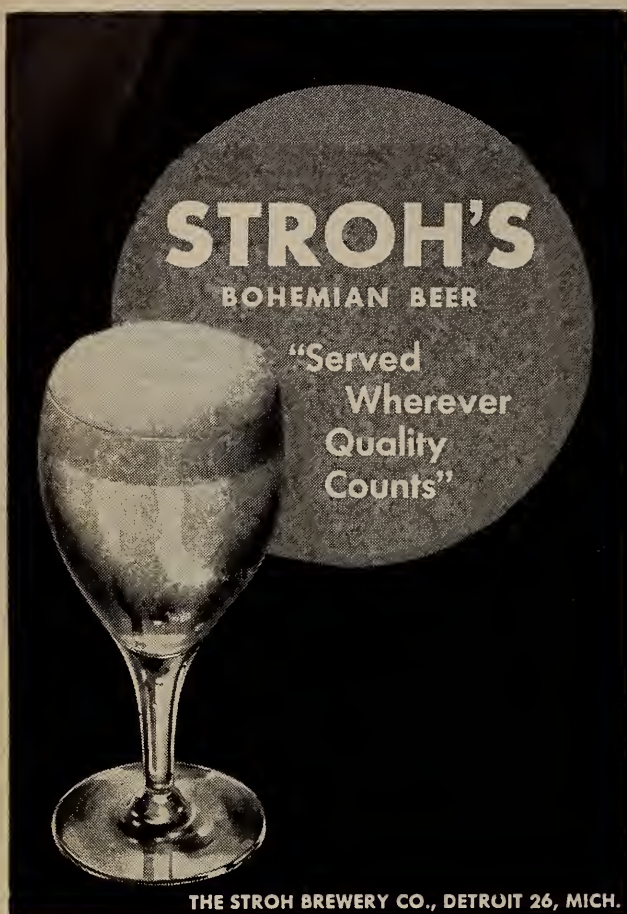
A committee was appointed to draft a constitution and by-laws and to pass upon applicants for membership. At the November 21, 1902 meeting, S. C. Graves, M.D., was elected as first President of the Kent County Medical Society; R. R. Smith, M.D., Vice President; F. J. Lee, M.D., Secretary, and L. E. Best, M.D., Treasurer.

J. B. Griswold, M.D., R. H. Spencer, M.D., and D. Emmet Welsh, M.D., were elected as members of the Board of Directors.

The first meetings of the Society were held in the Farmers' Club Rooms, County Building.

CONGRESS ON MEDICAL EDUCATION

The Council on Medical Education and Hospitals has announced that the Annual Congress on Medical Education and Licensure will be held at the Palmer House in Chicago on February 11 and 12. The session will deal primarily with reconversion problems, including the continuation education of physician veterans, the relocation of physicians and the transition to a peacetime educational program in medical education.



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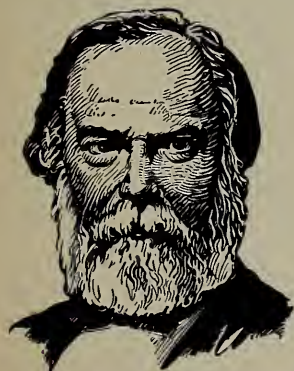
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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

PLASTER-OF-PARIS TECHNIQUE IN THE TREATMENT OF FRACTURES AND OTHER INJURIES. By T. B. Quigley, Lieutenant Colonel, Medical Corps, Army of the United States; Instructor in Surgery, Harvard Medical School (in absentia); Junior Associate in Surgery, Peter Bent Brigham Hospital, Boston (in absentia). New York: The Mac-Millan Company, 1945. Price \$3.50.

This volume is unique in its treatment of disease. It discusses one method of treatment, and in that discussion tells the mechanics of application. The plaster cast is the most useful method in treating most fractures, and many other wounds. This author tells how to apply the cast, why, and what the materials are. He advises commercial plaster rolls, but tells how to make them, and, most important, how to apply them. He mostly describes making his leg, arm and other casts from strips moulded in place, and bound by a few rolls of plaster bandage. He avoids rolling the cast from rolls, which is most frequently done. He thinks the strips make better casts. He tells how to make the cast look nice and polished, stresses care in having no wrinkles or folds that may cause harm. He insists that pain four hours after the cast is applied and the patient recovered from the anesthetic must be investigated as

(Continued on Page 1400)

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(Continued from Page 1398)

great harm could be done. The reviewer having just been fifteen weeks in plaster appreciates this author and recommends his book.

ESSENTIALS OF NEURO-PSYCHIATRY. By David M. Olkon, S.B., A.M., M.D. Associate Professor of Psychiatry, College of Medicine, University of Illinois. Illustrated with 128 Engravings. Philadelphia: Lea & Febiger, 1945. Price \$4.50.

The diagnosis of neuro-psychiatry is made much clearer by this book, which presents the fundamental principles, and classifies them in relation to genetics, psychological, psychiatric and medical symptoms present. Up-to-date information in diagnosis and treatment is presented throughout. Behaviorism, psychoanalysis, analytical psychology are reviewed in relation to newer methods. The book should be especially helpful to the student and the general practitioner who has to solve these problems in some of his cases.

TAKE IT EASY, THE ART OF CONQUERING YOUR NERVES. By Arthur Guy Mathews, with 26 Symbolical Illustrations by the Author. 239 pages. New York: Sheridan House, 1945. Price \$2.98.

This book is written in a free and easy conversational tone, with numerous quotations, and illustrative conversations, telling about the need to "take it easy" when dealing with so many nervous conditions, and the necessity of the patient doing the same thing, with methods of accomplishing that ideal. Many symptoms are real but are partially self-suggested. All the statements may

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not stand the test of trial, but many are reasonable, and all are worth the time necessary to read the book. Well printed on lightweight nongloss paper, the book is inviting to read.

CLINICAL TRAUMATIC SURGERY. By John J. Moorhead, B.S., M.D., F.A.C.S., D.S.M., D.Sc. 700 pages Philadelphia: W. B. Saunders & Company, 1945.

This volume is a comprehensive presentation of the management of the injured. In the main the author's opinions and methods based on long experience are presented in a convincing manner.

The book, although brief and concise, is very readable, abundantly illustrated, well organized and excellently indexed. The general practitioner will find it a most useful reference in cases of the multitude of so-called minor injuries.

Emphasis on the industrial aspects and the special section on the "Medico-legal Phases of Trauma" make it a valuable addition to the industrial surgeon's library.—
JOHN ROBERT, M.D.

ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY of the American Medical Association for 1944. Cloth. Price, postpaid, \$1.00. 238 pages. Chicago: American Medical Association, 1945.

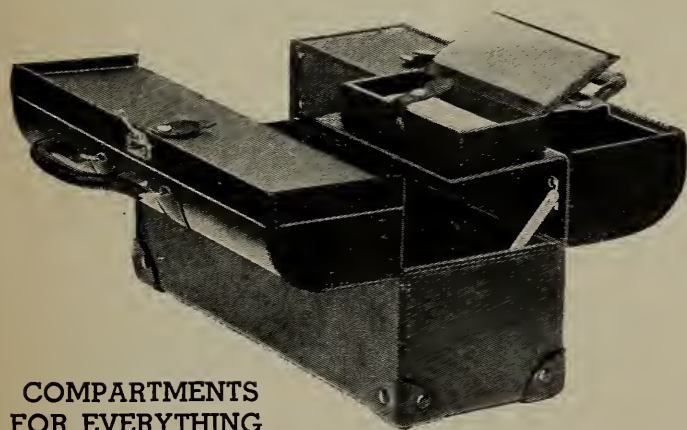
The Council on Pharmacy and Chemistry recently issued the thirty-sixth edition of the Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association. This volume contains in compact form not only the reports of the



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Council which have been published in *THE JOURNAL* during the past year but also some additional reports which were not considered of sufficient importance to be published in *THE JOURNAL*.

The present volume is quite unusual in that it contains not one report concerning a product found unacceptable. However, there are five reports on the omission of products from New and Nonofficial Remedies, mainly for the reason that they have outlived their usefulness, and in most cases the manufacturers have expressed their lack of desire for continued inclusion of their brands.

NEW AND NONOFFICIAL REMEDIES, 1945, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1945. Cloth. Price, postpaid, \$1.50. 760 pages. Chicago: American Medical Association, 1945.

Each year a revised list of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association as of January first is published in book form under the title of "New and Nonofficial Remedies." The book contains the descriptions of acceptable proprietary substances and their preparations, proprietary mixtures if they have originality or other important qualities, important nonproprietary non-official articles, simple pharmaceutical preparations, and other articles which require retention in the book.

Some fifteen or twenty newly accepted preparations appear in the 1945 volume. A large number of preparations have been omitted, mainly brands of official preparations. The general statement concerning these phar-

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macopeial preparations has been retained for the information of physicians.

As stated in the preface, the entire book has been scanned to bring it up to date with the latest medical knowledge. It is noted that the section "Articles and Brands Accepted by the Council But Not Described in N.N.R.," a vestigial remnant of which appeared in the 1944 volume, has now entirely disappeared.

This section appeared to have been a catch-all for brands of official articles the acceptance of which the manufacturers desired for reasons of prestige, and miscellaneous preparations which were not necessarily or importantly within the Council's scope and which did not require detailed description. Many of the official preparations have been transferred to the body of the book and the others deleted. One is struck by the large amount of medical information contained in this volume. Certainly no other compendium of comparable price contains so much.

THE OSSEUS SYSTEM. A Handbook of Roentgen Diagnosis. By Vincent W. Archer, M.D., Professor of Roentgenology, University of Virginia Department of Medicine. Chicago: The Yearbook Publishers, 1945. Price \$5.50.

This is one of a series of handbooks on Roentgen Diagnosis; and is especially written for the man doing occasional work in x-ray. In the Preface the author cautions that wherever possible a specialist should be used, but in so many cases that cannot be done, and so this book shows the methods to be used in taking films, shows the interpretation, points out the distinguishing signs to depend upon, and cautions that mistaken diagnoses have been made and have led to trouble. He points out such mistakes and tries to lead the reader to the right result. The book is up to standard, well illustrated, clearly printed from the standpoint of x-ray films, and

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NEW GOALS FOR OLD AGE. Edited by George Lawton. New York: Columbia University Press, Morningside Heights, 1945. Price \$2.75.

A course, "Mental Health in Old Age," was conducted under the auspices of the Section on Care of the Aged of the Welfare Council of New York City during the

year 1940-1941. These papers were first delivered there, and they comprise interesting discussions of such subjects as "Adjustment over the Life Span" by Lawson G. Lowrey; "Aging Mental Abilities and Their Preservation," George Lawton; "The Older Person in the World of Today," Ollie A. Randall; "Physical Changes in Old Age and Their Effects upon Mental Attitudes," Lewellys F. Barker; "Old Age at the Crossroads, Patterns of Living in an Institution," Helen Hardy Brunot, and "In the Community," Ruth Hill. There are sixteen such essays, and they are challenging considered with the increased interest in geriatrics.

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CONTINUOUS CAUDAL ANALGESIA

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First Annual Conference of Presidents and Other Officers of State Medical Societies

Chicago, December 2, 1945

THE CONFERENCE of Presidents and other officers was held in Chicago, Sunday, December 2, 1945, in the Tropical Room of the Hotel Continental. Sponsored by the California State Medical Association and the Michigan State Medical Society, the meeting was presided over by A. S. Brunk, M.D., Past President of the Michigan State Medical Society. The invitation went to Presidents, Presidents-elect, Secretaries, Editors, and Executive Secretaries. There were 208 registered, representing forty-two State Medical Societies.

This was a significant effort in public relations. Several resolutions were adopted, after months of study by committees and consideration by special reference committees of the Conference.

The program consisted of a report of the Committee of Ten, the Executive Committee of Presidents of twenty-five states. Committees were appointed, and resolutions were presented and referred to the committees.

Program

The Challenge

"How Can We Assure Adequate Health Service for All the People?"—ARTHUR J. ALTMAYER, Washington, D. C., Chairman, Social Security Board

How the Medical Profession Can Answer Today's Challenge

"Expansion of Voluntary Group Health Care Programs"—JOSEPH H. HOWARD, M.D., Bridgeport, Conn., President Connecticut State Medical Society

"Health Legislation Beneficial to the People"—PHILIP K. GILMAN, M.D., San Anselmo, Calif., President California State Medical Association

"Modern Medical Public Relations"—O. O. MILLER, M.D., Louisville, Ky., Past-President, Kentucky State Medical Association

"Formation of a National Health Congress"—JOHN F. HUNT, Chicago, Ill., Vice-President, Foote, Cone & Belding

Round-Table Discussion, Leader: E. J. McCORMICK, M.D., Toledo, Ohio, Past-President, Ohio State Medical Association

Reports of Committees

L. H. SCHRIVER, M.D., Cincinnati, President, Ohio State Medical Association, presented the committee report on Resolutions Re Health Legislation Beneficial to the People. This resolution is the composite of the drafts

submitted by the committees of eleven State Medical Societies and consolidated as follows:

Resolution Re Health Legislation Beneficial to the People

WHEREAS, It is the earnest desire of the medical profession of this country to provide better health care for the American people and improve health facilities and standards, therefore be it

RESOLVED, That the following principles for a health legislation program be adopted:

1. Establishment in the President's Cabinet of a Secretary of Public Health and Medical Welfare, who shall be selected from the ranks of actively practicing physicians, and under whose jurisdiction every federal bureau and office, whose duties are related to health and medical welfare, shall be grouped.
2. Encouragement of medical and other scientific research and study for the continuous improvement of medical care, by government grants-in-aid.
3. Provide federal or state loans, or guarantees of private loans, for the expansion of hospital and educational facilities, the operation of same to be entirely supervised, controlled, and carried on by those who own such facilities and by the medical profession.
4. (a) Establish state-wide voluntary non-profit health care programs, in every state, based on the free choice of purveyors of health care; such programs shall act as a service plan to all in groups classified as within a special income level as determined by the plan in each state or regional unit; as an indemnity plan for those classified as above that income level by each state or regional unit; as a service plan to the indigent and semi-indigent by contractual arrangement for payment of charges from county, state, or federal funds; as a service plan for all other governmental categories eligible for health care; as a service plan for all physicians' services to veterans of the armed forces for all illnesses or disabilities eligible under the law.
(b) Any further federal or state programs for expansion of medical service to be developed within the structure of the above-described program.
(c) National co-operation with the proposed plans of Maj. Gen. Paul R. Hawley of the Veterans' Administration in the therapeutic administrations to veterans for service-connected disabilities. Also for the development of veterans facilities as teaching hospitals under the medical direction of civilian consultants in the respective specialized medical departments.
(d) All state-wide medical care programs on either a

(Continued on Page 14)

HOW CAN WE ASSURE ADEQUATE HEALTH SERVICE FOR ALL THE PEOPLE?

A. J. ALTMAYER

Chairman, Social Security Board

IT IS a privilege to address a gathering such as this on the topic "How can we assure adequate health service for all the people?" I consider it also a great opportunity because—if we are to bring health services to all the people—the medical profession and the Government must work together. Obviously, the Government cannot achieve this objective without the co-operation of the medical profession, because medical service must be furnished by the medical profession. I believe it equally true that the medical profession cannot achieve the objective without the help of the Government. In the course of my talk, I shall explain why I believe that this is so.

At the onset, may I state plainly my opinion that there is no disagreement among us in our desire and determination that everybody, regardless of financial circumstances, shall be able to have adequate health services—meaning essential services of good quality. None of us wants to see anybody suffer or die for lack of medical care.

I believe also that the standards of good medical practice and of good hospital care in this country are probably second to none in the world today. The medical profession and hospital administrators have a right to be proud of the great progress these standards represent.

It is also true that, with few exceptions, the death rate in this country has declined year after year, particularly since the turn of the century.

Since all this is true, it may be asked, "Why is it necessary to embark on a national health program?" And, especially, "Why is it necessary for the Government to assume major responsibility?"

The answer is twofold. In the first place, while we have made notable progress in reducing the death rate in this country, we are not the healthiest nation in the world. In the second place, while we have achieved high standards in medical and hospital care, this high-quality care is not within the actual reach of large numbers of our people. Putting it bluntly, there are many Americans this very minute who are suffering and dying needlessly for lack of medical care.

United States Not the Healthiest Country in World

The statement has been made many times that we are the healthiest nation on earth, but statistics for the years just preceding the war show conclusively that we are not. Probably the best single measure of our relative health status is the infant mortality rate. In terms of this index, we stood seventh. Moreover, the comparisons in general were increasingly unfavorable to us as we proceeded from the death rates for infants to those of older groups of our population.

In addition, we should not draw too much satisfaction from the fact that our death rate has declined markedly since the turn of the century. We should not forget that

about 70 per cent of the reduction was made by 1920 and almost all of it by 1930. We must also remember that the major part of the reduction in death rates has been due largely or almost wholly to the reduction in deaths from infectious diseases that are susceptible of mass control. If we are to have anything like a similar improvement in death rates in the future, we must not only expand our efforts in the mass control of infectious diseases but also assure more nearly universal access to individual medical care of non-infectious diseases.

What should concern us more than comparisons with other nations or with former years is the fact that we have done much better in protecting health in some places than in others, for some types of diseases than for others, and for some groups of the population than for others. The real measure of our past accomplishments and of our future opportunities is what we can do with our available knowledge. As this group well knows, in many parts of the country and among many groups of our people, death rates are far higher than they need be.

Tuberculosis is still one of the dread killers. Yet we find that in a number of states death rates from tuberculosis are only one-fifth or one-sixth as high as in the state with the highest rate.

Infant mortality illustrates similar wide differences among the states. In 1943, the state with the lowest infant mortality reported 29 deaths per thousand live births; the state with the highest mortality had more than 3 times that rate. In some half dozen states with the highest infant death rates, at least half the babies who died could have been saved had they been fortunate enough to have been born in areas where conditions were more favorable for their survival.

The Financial Barrier to Adequate Medical Care

The availability or absence of medical care is not the only reason for these and other differences in the security of life in the United States. Differences in economic circumstances, and consequently in housing and living conditions, no doubt contribute to the differences in death rates. No economic factors, however, are as significant as the availability of public and individual provision of health and medical services.

It is still commonly said that the poor and the rich get the best care. This oft-repeated generalization has caused much confusion. The fact is that poor people have more illness and have higher death rates than the well-to-do, but they receive far less medical care per family and per case of sickness. Poverty, illness, and inadequate medical care go together. The National Health Survey, conducted by the United States Public Health Service in the winter of 1935-36, showed that there were two and one-half times as many days of disability among persons on relief as among those having a family income of \$3,000 or more. The number of days lost by persons

not on relief but with a family income of less than \$1,000 was twice that experienced by those with a family income of \$3,000 or more.

This Survey also showed that while there was much more serious disability among those with the least income, a substantially larger proportion among them than among those in the higher income brackets failed to receive any medical attention whatsoever.

The Survey also showed that disabled persons in the low-income brackets who did receive medical assistance had had fewer visits from physicians than disabled persons in the higher income brackets. Summing up the results of various surveys, it appears that the amount of medical care received by persons in the low-income brackets has been about one-third as adequate in amount as the care received by those in the upper-income brackets.

The reason for this difference should be obvious. Medical care costs money and the poor have less money to pay for it. Various public opinion polls show that from 30 to over 40 per cent of the American people have put off going to a doctor because of the cost. Individual doctors are not to be blamed for this. Financial barriers—not doctors—are the cause of the inadequate medical care which our people receive.

Government Responsibility for Meeting Health Needs

If we agree that nobody should suffer or die for lack of access to medical care, do we not have an obligation to break down the financial barrier between sick people and their doctors and hospitals? Is a democratic government meeting its full responsibility if the primary essential of human existence—the health of the people—is not safeguarded and improved to the utmost extent that medical science and our resources make possible?

That this is an accepted responsibility of government is recognized by the fact that our government has already gone a considerable distance in protecting and promoting the health of the people. In addition to public sanitation and public health services, we have provided public medical services for the indigent, though with widely varying degrees of adequacy in different localities. Nor has governmental assistance for medical care been limited to indigents. In 1944, 85 per cent of all the beds in tuberculosis hospitals were in government-operated institutions. Hospitalization for persons afflicted with nervous and mental disease has become almost exclusively a government function, and this hospitalization has by no means been limited to the indigent.

Even in the field of general hospital care the role of government has become increasingly important. In addition to the hospitals for veterans and other wards of the Federal Government, about 28 per cent of all the beds in general and special hospitals are in government-owned institutions.

Through workmen's compensation laws, the state governments and the Federal Government have assured medical services for work-connected accidents and diseases.

Of course the Federal Government has always been responsible for the medical services of the armed forces. In addition, it has provided hospital and medical care

for merchant seamen for a century and a half. For more than a quarter of a century special provision has been made to assure hospital and medical care for veterans. This activity is destined to grow by leaps and bounds. Thus, it is estimated that in the next 30 to 40 years the government will be providing hospital and medical care for 15 to 20 million veterans.

Under the Social Security Act, the Federal Government has made grants-in-aid to states for maternal and child health services, services to crippled children, and state and local public health services. It also has been providing funds for the control of venereal diseases.

Since 1942 the Federal Government has been paying for the maternity and infancy care of the wives and infants of servicemen. During the last fiscal year the expenditures under this program alone amounted to \$45 million.

Last year the new Public Health Service Act became law, increasing the financial support for public health and for research and authorizing a new, large-scale attack on tuberculosis. All in all, in 1944 governmental expenditures—Federal, State, and local—for public health and medical services, exclusive of medical care for the armed forces, totaled nearly a billion dollars, or one-fifth of all the expenditures for health and medical care in the United States.

Thus it is apparent that the question before us is not whether the government should assume responsibility for protecting and promoting the health of the people, but rather how much further the government should go in meeting that responsibility.

President Truman's Health Message

The President of the United States has placed his views before the Congress in his message of November 19, in which he outlined a national health program. The President's program consists of five proposals:

- (1) Federal grants-in-aid for hospitals and other health facilities throughout the Nation;
- (2) Federal grants-in-aid to expand public health services and maternal and child health services;
- (3) Federal grants for medical education and medical research;
- (4) A nation-wide system of health insurance, and
- (5) Compensation for wage loss due to non-industrial disability.

Time will not permit me to discuss fully all of these proposals. Therefore, I shall discuss only the proposal for a nation-wide system of health insurance, since that is the most controversial and is probably of the greatest concern to practicing physicians.

The question is whether it is still necessary for the government to take some action to spread the cost of medical care for self-supporting individual families if it does these other things, concerning which there is more or less general agreement. That is to say, would it be enough if the Federal Government expands its public health and maternal and child health programs, makes certain that hospitals, health centers, clinics and diagnostic facilities are available in every part of the country, and finances the cost of providing care of the indi-

gent? If all that is done, why cannot the normally self-supporting families be expected to pay for their own medical care either directly or through voluntary insurance plans of one kind or another? These are questions that deserve careful consideration.

Perhaps we can all agree that building hospitals and other health facilities is not enough unless provision is made so that sick people can avail themselves of these facilities. Unfortunately, in the very nature of the unpredictable incidence of sickness, it is impossible to draw a line between those who will be able and those who will not be able to pay for the health services they need.

The so-called "medically indigent" is a statistical term to describe classes of persons rather than individuals. Whether a given individual falls within the classification of medically indigent depends not only on his income but also on the amount of sickness that he happens to have. Dr. Leland, Director of the Bureau of Medical Economics of the American Medical Association, presented data in 1939 in which he showed that people with an income of less than \$3,000 a year may be medically indigent under certain circumstances—depending upon the type of illness they suffer.

If sickness were predictable and if it affected families equally, the problem of paying for needed medical services would be less serious. But, as we all know, sickness costs often come suddenly, unexpectedly, and in large amounts. One illness may involve a cost of only a few dollars and another illness may require more than the family income for weeks, months, or even years. No one knows when an illness may strike or how much it will cost.

Spreading the Cost of Medical Care

The only way most of the American people can meet this problem is by spreading the cost of medical care over sufficiently long periods of time and among large enough groups of persons so that the cost will not be unbearable in the individual case. If this were done, and the average amount were adjusted according to income, the cost of adequate medical care would not be unbearable even for persons with relatively small incomes.

If the problem is to spread the cost of medical care, the question remains, why can't we rely on the individual to obtain his own insurance? Hard facts spell the answer. The poor cannot afford to pay the full insurance premium. Most of those who are normally self-supporting have immediate wants which press on them to the exclusion of protection against future possible costs that may not actually occur. In other words, our day-to-day wants and necessities induce us to take a chance.

Inadequacy of Existing Voluntary Arrangements

It is true that many people have insurance against the cost of hospital or medical care. The Blue Cross movement, in particular, has shown remarkable progress in the last ten years. However, the present membership covers less than 13 per cent of our entire population, and is made up chiefly of people in the middle income brackets, who live in or adjacent to the larger cities. Prepayment plans for medical care came before the Blue Cross hospital plans, but they have not shown such rapid or extensive growth. Some medical society plans that started

out to provide comprehensive services have found their growth discouragingly slow and have restricted their main coverage to surgical expenses in hospitalized cases only. At present, membership in voluntary medical prepayment plans—which seldom provide complete or comprehensive medical services—includes about 5 to 6 million persons.

Commercial group insurance covers about 8 million persons for hospital and surgical indemnity insurance of which about 6 million are covered for surgical indemnity. The number of individual insurance contracts for indemnity of hospitalization and other medical care costs is not known. While it may be large, the scope of the protection is usually narrow, since many of these policies cover only costs incurred for particular types of accidental injuries, rather than sickness costs of all kinds, and many have other important limitations.

It is possible that, altogether, about 40 million persons have some voluntary protection against the costs of hospitalization or medical services. While this protection is significant, the available figures indicate that voluntary insurance alone does not assure adequate protection for most Americans against the cost of medical care. Moreover, when we consider the economic status of those who now have such protection and of those who do not have it—but do experience more frequent and serious illnesses—it becomes all the more evident that voluntary insurance is not a complete or adequate answer to this national problem of spreading the costs of medical care.

Distinction Between "State Medicine" and Health Insurance

There are two possible ways in which the government can undertake to spread the costs of medical care. One is through providing medical care free of charge to the recipient, financing it through general taxation. The other way is through a system of health insurance, financed largely through contributions by potential beneficiaries and their employers. Under the first approach, medical care would be provided just as education is now provided. The practitioners would probably be for the most part salaried officials employed by the agency of government providing the medical services. Such a system is usually termed "state medicine" and sometimes "socialized medicine." However, these terms are so indefinite and confused that they are sometimes used to cover not only public sanitation, public health services, and medical services provided by government for specific groups in the population, but also health insurance.

It is essential for clear thinking that the distinction between state medicine and health insurance be kept in mind. State medicine implies medical services provided by physicians employed by the government; health insurance, on the other hand, implies a system whereby medical service is provided by private, competitive practitioners who are reimbursed from a special insurance fund for the services they render. In other words, state medicine is not only a system for spreading the cost of medical care but also a system of medical practice; in contrast, health insurance is a system for spreading the cost of medical care and does not replace the competitive private practice of medicine. Only the Union of Soviet

Socialist Republics has a national system of state medicine; more than thirty countries have national systems of compulsory health insurance.

Every state but one already is operating a system of compulsory health insurance applicable to accidents and diseases arising out of occupation—that is, workmen's compensation. I am sure that no one would think of abandoning workmen's compensation insurance. It seems generally agreed that, in spite of recognized deficiencies, workmen's compensation has resulted in providing more adequate medical care for the victims of work accidents and diseases and more adequate compensation for the physicians and hospitals called upon to treat them. In the broader sense, health insurance is merely more inclusive than workmen's compensation; it covers *non-occupational* accidents and diseases.

Elements of a Health Insurance System

Many people sincerely believe that there is no essential difference between state medicine and health insurance. Perhaps outlining the elements of a system of health insurance will help to clarify the distinction. But first let me point out that health insurance is, of course, a form of social insurance. In addition to a form of health insurance—that is, workmen's compensation—this country now has unemployment compensation and old-age and survivors insurance. All of these are forms of social insurance and are financed by premiums collected as a percentage of payroll.

It would be possible to have a system of health insurance on a strictly state-by-state basis, like workmen's compensation, without any assistance from the Federal Government. Or it would be possible for Congress to enact legislation which would create a strong inducement for the states to enact such laws, as was done in the case of unemployment compensation. Or it would be possible for Congress to enact a wholly Federal health insurance law.

Decentralization of Administration

If Congress enacted a wholly Federal health insurance law, it would still be possible to allow for state administration. Contributions to finance the health services could be collected along with the contributions made under the Federal old-age and survivors insurance system without any additional inconveniences to employees or employers, and without additional cost to the Government. The added cost of administering health insurance as part of a unified social insurance system probably would not exceed 5 per cent of the total cost of benefits provided.

Free Choice for Patient and Doctor

The administration of the benefits should be decentralized so that all necessary arrangements with doctors and hospitals and public health authorities could be subject to adjustment on a local basis. The local hospitals and doctors should be permitted to choose the method of remuneration which they desire. The method of remunerating hospitals could be on a fixed per diem basis regardless of the cost of the service to the hospital or the patient, or it could be on the basis of the actual cost of the service to the hospital—within fixed minimum and maximum limits, or it could be a combination of the two methods. The payment of doctors could be on the

basis of fee for services rendered or a per capita fee per annum, or straight salary—part-time or full-time—or it could be some combination of these arrangements.

Besides free choice of method of remuneration, the system should provide, of course, free choice of physicians and free choice of patients. The professional organizations themselves should be relied upon to assist in the maintenance and promotion of desirable professional standards.

Both individual and group practice should be permitted. It would be hazardous for a layman to undertake to discuss with physicians the pros and cons of individual practice versus group practice. May I merely suggest that the development of adequate health facilities throughout this country, including hospitals, clinics, health centers, and diagnostic facilities, available to all of the physicians in a community, ought to help us to achieve the maximum advantages of both individual and group medicine?

Utilization of Voluntary Organizations

Voluntary organizations that provide health services would have an important role under a system of health insurance. So would voluntary co-operative organizations that are concerned with paying doctors, hospitals, or others for health services but do not provide these services directly. Specifically, medical society plans that provide services directly or pay for services rendered could play an important part in simplifying administration, promoting desirable professional relations, and furnishing—or arranging to furnish—adequate medical care promptly and efficiently.

Many of the state medical societies represented here today have worked hard to set up systems of prepayment of medical care. They have encountered great difficulties, with which you are as familiar as I. Several of these plans, however, have met with considerable success. But whether or not they have met with success, these plans represent an earnest attempt on the part of organized medical groups to spread the cost of medical care while maintaining the professional relations desired by those groups.

They have experienced one great difficulty that a general system of social insurance would overcome—the hazard of adverse selection. Any prepayment plan covering persons who can enter it and leave it at will is subject to this handicap. Under a general social insurance system, however, the problem of adverse selection is solved automatically, since the good risks as well as the bad risks are included.

Under a system of health insurance, the government could make arrangements to deal with the voluntary groups that furnish health services directly or pay for services rendered. The simplest arrangement would be for the government to reimburse the organization either on an individual patient or service basis, or on an estimated total cost basis, having regard for the number of insured persons that it serves. Such a relationship would involve a minimum of control by the Government and a maximum degree of independence on the part of the group and the members composing the group.

Such arrangements would not only provide for utilizing existing service organizations, but would encourage the

creation of new ones. Such voluntary plans could be administered by groups of doctors, individual doctors, or many other kinds of individual or group sponsors.

Any such plans would be as free as they are today to select their own staffs and their own method of paying doctors and others on their staffs.

Moreover, the method of paying a group for services rendered by their physician-members can be readily adapted to avoid adverse selection. For example, if the group is large and undertakes to serve a whole area or population group, it could receive a pooled payment from the insurance fund for all insured persons in the area or population group. This is payment according to number of persons and is generally known as capitation; the payment covers the well and the sick. Or, if the group prefers, it could be paid for the sick only, on a fee-for-service basis—so much for this service and so much for that. In either case, the group is protected against adverse selection.

Many variations and combinations are possible, depending on the nature of the group, what it is prepared, and equipped to undertake, and the preferences of its membership.

Under any method of payment, the rate of payment and the amount of payment to doctors should be adequate. This means adequate payments for general practitioner services and adequate payments for specialist services. The medical profession has a right to insist that the financial resources of a health insurance system shall be sufficient to pay adequately for high-grade services. Since the public would receive a larger amount of service with health insurance than without it, physicians as a whole would have a right to expect higher average incomes than they ordinarily receive.

Quality of Care and Freedom of Profession

I am sure you think that even ready access of the public to needed care and adequate payments to those who furnish care are not enough. There are fundamental questions with regard to safeguarding the quality of care and continuing professional progress. On these questions it is more appropriate that I listen to you, rather than you to me. There are, however, a few observations I would like to make.

By and large, it seems to me that quality of care should improve rather than decline if payment for service is guaranteed. It is alleged, however, that other characteristics of an insurance system will dominate the picture. And one hears about "regimentation" of doctors, "assignment of patients," "political control," etc.

We are agreed, I believe, that the patient shall have free choice of doctor, and that the doctor shall be free to accept or reject patients. If the fee no longer stands between patient and doctor, the competitive relation between doctors will still remain, but it will rest on quality and adequacy of care. These are essentials for continuing good care. Where then are the issues?

One question concerns control over the professional aspects of medical practice. This is an ancient question—older than the Hippocratic Oath. The guidance, the direction, the supervision, the discipline of doctors are primarily matters for doctors to handle. Subject to Government regulation through licensure, the responsibility

has always been yours and should remain yours. No government officer in his senses would take any other position. Just as public licensure gave the profession a new opportunity to deal with these problems, just as grading of medical schools, registration of hospitals, administration of workmen's compensation, and establishment of voluntary insurance plans—to mention only a few—gave you new opportunities to exercise professional controls, so inauguration of health insurance gives you still another in the long evolutionary movement for high ethical and qualitative standards. On this broad question, health insurance presents not a major threat but a new, great opportunity.

Another question is summarized in the phrases about "regimentation," "a czar over medicine," etc. There is one sure way for the medical profession to see that what it doesn't want doesn't happen, even by inadvertence; that is, to participate in planning the program. If you do, I am sure you will find you are working side by side with friends of the profession. There is no problem here that can't be solved by men of good will.

Professional Participation and Program Planning

I hope that I have succeeded in pointing out some of the essential differences between a system of State medicine and a system of health insurance. The first means a change from private medicine to public medicine. The second means changing from a pay-as-you-are-sick method to a prepayment method for spreading the costs of medical care.

However, even with this essential difference, it should be recognized that the medical profession has a justifiable concern as to the effect of a system of health insurance on the profession. The medical profession has a right to insist that the high standards of medical practice achieved in this country shall not only be maintained but also encouraged to advance as in the past. The medical profession has a right to insist that the doctor-patient relationship shall not be impaired in any way. It has a right to insist that its members shall be remunerated adequately for the services they render. Therefore, I believe that the medical profession should assist in developing legislation and should participate in the administration of the system that is enacted. I trust, however, that I may be forgiven for suggesting that organized medicine in this country should not give the impression of unqualified opposition to any governmental attempt to spread the costs of medical care.

Public Opinion Polls

Though hazards are involved in any governmental attempt to meet the problem of spreading the costs of medical care, I believe we must recognize that there is a large and growing demand by the people of this country that the Government act. Every unbiased poll that has been taken in the last ten years shows that this is so. I have no doubt that another speaker on the program this afternoon, who is a specialist in appraising public opinion, will be able to furnish you more information on this score than I.

As you know, the British Medical Association, as a

(Continued on Page 20)

EXPANSION OF VOLUNTARY GROUP HEALTH CARE PROGRAMS

JOSEPH H. HOWARD, M.D.

President Connecticut State Medical Society
Bridgeport, Connecticut

IN THIS "atomic age" events sometimes move as swiftly as machines and missiles.

Since this meeting first was arranged, there has been introduced in the Congress of the United States still another version of the Wagner-Murray-Dingell Bill, and simultaneously the President of the United States sent a message to Congress urging the immediate passage of legislation for a compulsory health insurance program which would include all of the people of the United States.

Except for the huge pile of appropriation bills and other emergency legislation which must be disposed of in the next few weeks, it might well be that this latest Wagner-Murray-Dingell Bill could be rushed through Congress before even a semblance of debate. However, the interest which President Truman has taken in this program indicates that it will not be shelved, and that we may anticipate final action by Congress on whatever form the bill is to take, at a very early date.

Clearly the time for argument has almost run out. The time for action is here, and those who know what the evils of compulsory insurance would be must be prepared to meet constructively the benefits which are sought, through a comprehensive medical care program on a national basis.

There is an axiom of politics which the late Al Smith used to quote even though he may not have been the originator of it, and it said: "You can't beat somebody with nobody."

It is not my function at this time to marshal the arguments against Government control of the care of private health. Those arguments are impressive, but we must realize that a need exists for better provision for building the national health, and it is up to the medical profession to take the leadership in doing it or to surrender the responsibility to those in whose hands we would not like to see it placed.

"States' rights" has been an issue in the political life of our country ever since it was founded. Great leaders have joined the issue on this question, but our own Governor Baldwin of Connecticut and other foresighted leaders of political and economic thought have said that the only way that states' rights can be maintained as against the ever-increasing power of the Federal Government and its incursion into the lives of all of the people, is by meeting the needs of our people promptly and better than can be done by the national government.

We have seen many of the things that federal control can do to our daily lives, in the effect of the regulations under which we worked during the war just closed. We can observe the efforts of the ardent advocates of a more powerful Federal Government in many phases of our daily lives—the efforts to federalize education, the efforts to federalize all hiring and firing, the "ceilings" on prices, wages, and, in fact, almost everything that affects our daily lives.

President Truman, in his historic report on his conference with the heads of the other great powers at Potsdam, stated, "The war has shown us that we have tremendous resources to make all the materials of war. It has shown us that we have skillful workers, managers, and able generals, and a brave people capable of bearing arms. The new thing, the thing we have not known, the thing we have learned now and are never forgetting is this—that a society of self-governing men is more powerful, more enduring, more creative, than any other kind of society, however disciplined, however centralized. We know now the basic proposition of the work and dignity of man is not a sentimental aspiration or a vain hope or a piece of rhetoric. It is the strongest and most creative force now present in this world."

This does not sound like the same Mr. Truman who gave us the socialized medical program of last week.

On the very day that President Truman sent his message concerning a national health program to Congress, Senator Wagner, in introducing the new bill, accompanied his remarks by a statement which he inserted in the *Congressional Record*, purporting to give the "answers" to questions which had been raised or would be raised about the prepaid medical care provisions of his proposed "National Health Act of 1945," and to the question about "socialized medicine," Senator Wagner said, "The bill does not provide for 'socialized medicine' if by the term is meant medical care furnished by government doctors, free of charge."

You will see that this is a very narrow definition, and you will see further by an examination of the bill that it is socialized medicine.

Yet the President has taken the words of Senator Wagner and said, "This is not socialized medicine. We do not want socialized medicine."

Well, it is federalized medicine, and this nation has had some rather unpleasant experience with federalized medicine during the war, with some of the medical programs carried out under the Children's Bureau which were claimed to be merely emergency measures that would be required only during the war, but they are still being carried on after the war under the so-called Pepper Bill. If such a program is given to us as non-socialized medicine, you can be sure that it is inevitably a step towards socialized medicine, if the doctors agree to the present program.

Under the cloak of the favorite expression, "free choice of physicians," the bill covers some dangerous provisions and developments. By the use of this expression, the people, it would appear, will think that when this bill is passed, they can call their own doctor any time to be taken care of; but they do not tell us in this bill that the "free choice of physicians" includes only those physicians who are participating in the program. Therefore, if a family has a particular family doctor, and he does not participate in the plan, that family still will pay its

taxes under this bill, but they will have to call the family doctor and pay him if they want him.

Another significant thing about the bill and about the discussion of it by its proponents is that the real cost of the measure is not made clear. Nowhere in the bill is the term "taxes" or "taxation" used. The proponents tell us that this is a "contribution" by the worker to this particular program. Therefore, by using the term "contribution" and not "taxation" it will include all those non-taxable people who previously had a free choice as to payment for medical care, such as members of the Christian Science Church, members of the clergy, and other groups. In answer to a question in the Senate, Senator Wagner said the bill is "all-inclusive," and therefore agricultural workers, self-employed, and all other persons and groups would be making their "contribution" to this plan.

One of the great newspapers of the Midwest, the *St. Louis Globe Democrat*, says this bill, if carried to its logical conclusion, "would destroy the medical profession as it exists today and would establish the Federal Government as the director of a national social insurance system consisting of prepaid personal health service."

A most telling point is made by the *JOURNAL* of the Michigan State Medical Society which says, "Basically, socialized medicine is only a new approach to another payroll 'take' by those public spenders who now feel the need for new worlds to conquer in the realm of spending other people's money."

Dr. Morris Fishbein, in his editorial in the *AMA JOURNAL* this week, says, "The time may yet come when the American worker, as was the case with the German worker, will have more deductions from wages than 'take home' pay."

This bill is open to attack from the standpoint of its soundness, but one of the things that will make it unpopular with the people will be the way it piles up additional deductions from the workers' pay, a condition which reached the breaking point after V-J Day, when industrial and other workers felt that after deductions for withholding tax and numerous other items, they were not faring very well in the amount of money left to them to take home.

The *Buffalo Evening News* says, "Every reasonable consideration urges rejection of the Wagner-Murray-Dingell Bill. It must be recognized that public health services will have to be increased. The people thus look hopefully to the American Medical Association for the Extension of Medical Service to point the way for such improvements. *It is upon the medical fraternity that the burden of proof rests.*"

The medical fraternity recognizes its responsibility and that is why we are preparing, at this session and at others, the constructive suggestions which will make a program to be offered to the people of the United States as a valid substitute for the socialized medicine of the "National Health Act of 1945."

I attended a meeting in New York City the other day of the National Physicians' Committee, and it was interesting to note that a survey made by Dr. Claude Robinson of Opinion Research Corporation showed that of three different types of medical plans, first, that of group insurance, 87 per cent; second, the federal plan,

67 per cent; and third, the physicians plan, 62 per cent. It is also interesting to note that the best known plan to individuals polled in this survey was first, the plan of group insurance, then the federal plan, then the plan of the physicians.

Among the members of the well-informed groups questioned in the survey, the prepayment medical plan of physicians came first, which emphasizes the point that the lack of education of the people in prepayment medical plans by state medical societies is apparently the reason that in the larger poll, the plurality voted the other two plans as most popular.

In this sampling of public opinion by Opinion Research, the statistics showed that seventy-one per cent of the American people knew that there were some plans for prepayment medical and hospital care in operation, and seventy-eight per cent of the people are interested and want some type of plan.

There is no doubt about it, the American people want security against unpredictable financial loss due to ill health and injuries. At this point, many do not seem to know that there are alternatives to Government action so far as provision for medical care with a convenient method of payment are concerned. That is because a part of the medical profession has not assumed its full responsibility in developing and advancing the voluntary program.

The development of voluntary medical care programs and the experience under these various programs can be consolidated to offer the right answer to the compulsory medical care program as advocated by President Truman.

Voluntary medical care programs are sponsored by state and county medical societies, and are increasing every day. There are more than forty bureaus for executing such programs in twenty states, and two additional states are organizing plans at the present time. Of these programs, eleven are statewide, and twenty-nine are local. Thirty-six are in operation with enrolled subscribers, while four are in the organizing stage, but as yet have no enrollment.

A conservative aggregate of the enrollment of these medical care programs is 2,476,321. However, there are only about 8,000,000 persons out of a total population of 136,000,000 Americans who are covered under the plans, or about six per cent of the total population. One of our major objectives must be to increase this movement rapidly and largely if we are to combat the federal program.

A study by the Research Council for Economic Security of Chicago, prepared upon data from the Health and Accident Underwriters Conference, shows that more than 40,000,000 Americans are estimated to enjoy health and accident and hospital insurance protection care under voluntary programs, and the same study also shows that the rate of growth in number of persons protected by health and accident and hospital insurance policies has been much more rapid than the rate of growth in premium income.

The reason is that health and accident and hospitalization protection has been made more generally available to the working people through the rapid development of group insurance. In 1920 there were about 4,000,000 people covered by voluntary health and acci-

dent and hospital insurance; in 1944 there were more than 40,000,000.

The Research Council very properly says, "This makes it evident that the percentage of population protected is rapidly approaching a figure which will refute completely the argument of advocates of compulsory governmental programs, that the people who really need protection are not being reached under the voluntary programs now in operation."

The objectives, the problems, and the possibilities of professionally supported prepayment programs are everywhere broadly the same. They are a product of American medicine as a whole, and are not the exclusive development or property of any one segment or district or state. They seek to solve a problem, national in scope. Therefore, the principles which guide this movement for voluntary prepaid medical care are universal, even though there may be variations in details.

Distasteful though it may be, the time has come when the medical profession must concern itself with economic problems, because if we abandon the control of the economy of medicine to some authority outside the profession, and particularly to the Federal Government, scientific freedom cannot survive.

Our political leaders are not unmindful of the general state of popular sentiment and opinion in favor of some type of health insurance. That is why the administration at Washington has moved so swiftly for the adoption of the latest version of the Wagner-Murray-Dingell Bill. If the medical profession does not go "all out" in providing the medical and hospital care that is needed, it is obvious that public demand will encourage the political leaders to have the Government provide it.

In an effort to dramatize poor conditions of health among the American people, who incidentally are the healthiest nation in the world, and have been made so by our free independent type of medical care, as opposed to "state medicine" in Europe, President Truman asserts that 5,000,000 men were rejected from the draft because of some disability," and infers that under a federalized medical program this number would be cut down materially.

Of course, in using this fact as an argument for federalized or socialized medicine, the proponents do not break down those figures to show that a large percentage of those rejected were totally disqualified because of blindness, or deafness, or the loss of a limb, nor do they point out that more than 700,000 had mental or nervous diseases, or that a half million were mentally deficient; nor do they disclose that in this figure are included hundreds of thousands of men who were rejected by selective service for certain conditions which socialized medicine could not have changed. They do not tell you either, that although in the United States, thirty-eight per cent of those called for induction were rejected, in England, where the standards of induction were not so high as those in the United States, the rate of rejection was fifty per cent, and England's socialized medicine health insurance program has been in operation for a whole generation. Supporting the administration and Senator Wagner and the other proponents of the "National Health Act of 1945" are groups from organized

labor, "reform" and philanthropic organizations, the Social Security Board, and those who foster a philosophy of collectivism.

As the issue is joined for the battle in Congress over this proposal for federalized medicine, those who are known to be opposed to it include insurance companies, industry, commercial groups, the medical profession, and other citizens who believe in continued operation and strengthening of free and individual enterprise.

The battle for winning the support of the rest of the electorate of this country is now on, and it will be very largely action and facts which will tell the story best. I have pointed out that the people as a whole are in favor of some form of health insurance, but when the cost of the federal program is realized, they will be very much opposed to this burden, which is likely, under the provisions of the pending bill to run to about ten per cent of the entire national payroll.

Studies which have been made of the several types of prepayment plans sponsored by the physicians show that the cost of coverage may be estimated at about one-fourth of the cost of a federal program.

Senator Wagner has inserted in the *Congressional Record* messages which purport to be an endorsement of the principles of the "National Health Act of 1945," by the American Federation of Labor and by the C.I.O.; but the "new charter for labor and management" which was announced early this year by President William Green of the A.F. of L., President Philip Murray of the C.I.O., and President Eric Johnston of the United States Chamber of Commerce, said, "The rights of private property and free choice of action under a system of private, competitive capitalism must continue to be the foundation of our nation's peaceful and prosperous expanding economy. Free competition, and free men are the strength of our free society."

The way to combat this federalization of medicine is by the development of voluntary plans in the various states. During the legislative session of 1945 more than thirty bills proposing cash sickness benefit plans, or compulsory health insurance systems were introduced in twelve state legislatures. Other bills called for studies of health insurance.

Under the compulsory type of insurance, of course, everybody would be required to pay taxes regardless of whether or not he sought medical care. Peculiarly enough, the greatest demand for compulsory health insurance comes from those states which were best supplied by hospitals and physicians. For instance, in New York state there were twenty-seven health insurance bills introduced in the assembly between 1935 and 1945. Yet New York has far better medical and hospital facilities than the average state. On the other hand, the Southern states such as Mississippi, Alabama, and others, where the need for medical care is most acute, have practically no organized demand for compulsory health insurance. One may wonder what, then, is the reason for this movement in New York and other states for a compulsory health insurance bill.

The most powerful single force which is promoting the demand for compulsory health insurance is organized labor. The time most conducive for this demand is a period of depression. The place of such demand is the

large industrial center where employment may have declined and where earnings may be low.

The need for improved medical care, particularly in some areas of this country, may be conceded and need not be argued. The form that this program should take is what is in question, also the administration of it, the benefits, and other details. Comprehensive statistics on the extent and prevalence of disease in the various states have not been obtained. Therefore, a complete study should be made first.

In considering any national health program we must think of three major points: First, the need for supplying medical care and hospital service where none now exists; second, the need for better sanitation and hygiene; third, the need for economic development and improvement of the working conditions of the people, which will help to overcome some of the deficiencies which lead to disease.

All these points above are approved by the American Medical Association; the first was included in the Hill-Burton Bill, and the medical profession is back of it. Concerning the second point, this is a public health measure which should be developed by local communities with the aid of states and of the United States Public Health Service. The third point involves an expanding of our national economy, which can be accomplished only by less federal control and the encouragement of free enterprise.

In accepting the responsibility for meeting the needs of our country for improved health and better financing of medical care, medical leaders must have certain well-defined and unified objectives, and the following are proposed for your consideration:

Establish state-wide, voluntary, non-profit health care programs in every state, based on the free choice of purveyor of health care. Such programs will vary in each state depending upon the type of policy written. For example, an indemnity plan for those classified as above the income level by each state or regional unit, and a service plan for the indigent and low-income families by contractual arrangement for payment of charges by the county, state, or federal government; a service plan for all other governmental categories eligible for health care; a service plan for all physicians' services to veterans of the armed forces for all illnesses and disabilities. Further federal or state programs for expansion of medical service may be developed within the structure of the program described here.

All state-wide medical care programs on either the service or the indemnity care basis should be incorporated under state enabling acts or under existing statutes. This will provide for either a prepayment medical plan, or a reimbursement contractual service.

With co-operation and reciprocity on a national level between all state plans for voluntary medical and hospital care, it will be possible to include these essential features of the program, as operated by the medical societies:

1. Active professional participation, support, and control.
2. Determination of fees by doctors of medicine.
3. Non-profit operations.

4. Co-operation and co-ordination with hospital service programs to provide a full health protection, and reduce overhead.
5. Broad, liberal benefits, at the lowest possible cost.

Any medically-sponsored plan ought to protect all of the people against illness or injury. In other words, the protection should be extended not only to a worker, but to the members of his family as well.

In the beginning, any medical care program should provide at least coverage of surgical services rendered in a hospital:

1. Surgical services.
2. Maternity services after a nine-month waiting period.
3. Anesthesia, rendered by a Doctor of Medicine.
4. Diagnostic x-ray services not to exceed \$15 in any certificate year.
5. Emergency surgical service not requiring bed care, rendered in a regularly accredited hospital by a Doctor of Medicine, during the first twenty-four hours following accident or injury.

After experience has been obtained under this surgical plan, medical service in the hospital should be added as soon as possible to include:

1. Surgical benefits as outlined above, plus
2. Medical (non-surgical) services to a total of thirty days during any or each certificate year.

Later, complete medical coverage in the doctor's office, in the patient's home, as well as in the hospital should be offered. Extension and liberalization of all health benefits should be made available as rapidly as sound financial operation will permit. Complete health prepayment for the self-supporting must be the ultimate goal.

Next, let us consider the health care of those unable to pay. Financial responsibility for the care of the indigent traditionally has been a government function, and this must remain with government. Government and the medical profession must undertake a program for the more effective co-operation arrangement in the field of health, so that the indigent may have the same free choice of Doctors of Medicine and hospitals as the self-supporting.

This complex problem is made simple by the professionally administered group health care program. Incidentally, use of such a program calls for the adoption of a uniform fee schedule which puts an end to the unfair practice of forcing physicians to accept a fifty per cent discount for the care of government wards.

The new philosophy is—"in the light of modern conditions, changes, and trends, and the creation of new groups and categories—since in the past the medical profession has sold its commodity of service to government agencies at less than cost—that the minimal fee in the future shall be commensurate with the work done."

The time is here to withdraw the philosophy of a special discount rate to government for care of wards of government.

Another greatly increasing category, the wards of government, including veterans, rehabilitated persons, crippled persons, etc., will all gain better health care from a co-operative arrangement between government and the medical profession. The extension of the facilities of the Doctors' voluntary, prepayment health care projects, and the recent reorganization of the Veterans' Administration, bring hopeful signs that such co-operation will be more than wishful thinking. The home and office medical care and emergency hospitalization of veterans by private practice of medicine, that is the use of the physician-patient relationship, may be a boon to the veterans.

I would like to stress the need for a national voluntary prepayment health service plan, uniform in general principles, with reciprocity among states, so that practically the same benefits are offered in any or all parts of the country at the same subscription rates, to facilitate enrollment of national groups, as well as to permit a continuation of coverage to those whose work moves them from one section of the country to another.

Approximately 60 per cent of the business in America is on an interstate basis, and the necessity, therefore, of some master plan in the various states to cover people moving about from one state to another is most important.

I believe, therefore, that the medical profession must offer a national medical program which guarantees that the subscriber receive the service he needs when he needs it, any place in the United States at no additional expense.

A good example of this is offered by the New York State Medical Society, which at a recent meeting of its House of Delegates approved without a dissenting vote a resolution that the Society create a special committee to investigate the feasibility of developing and putting into operation a national casualty indemnity corporation chartered under the laws of the state of New York.

Efforts must be made by the medical men of each state to obtain a large support from the workers insured under prepayment care plans, and this is possible only through a nation-wide plan operating in all the states.

The cost of medical care in relation to income shows that persons of an income less than \$1,000 a year spend 6.8 per cent of their income on medical care. This decreases as the income increases, so the people with an income of more than \$5,000 spend 2.4 per cent of their income on medical care. This shows that the lower income group, of course, are living on sub-minimal and faulty diets which may lead to physical complications requiring them to spend such a large percentage of their income on medical service. Compulsory medical service will not correct that, but improving the standard of living of these low-income groups will do more to cut down the cost of medical care than any federalized program.

Our parent Medical organization should act now in the development of a program for group medical service on a nation-wide basis, correlating all the independent state plans. In those areas which have voluntary group medical plans, the people are appreciative of the offer made by the profession, and the enrollment is increasing very rapidly.

The latest information that comes to us is that new members are enrolling in voluntary non-profit plans at the rate of almost 17,000 persons a day as compared with last year when the enrollment was at the rate of about 12,000 per working day.

A good example of the momentum that this movement has gained may be seen in the situation in Yonkers, New York, which is a city of slightly under 150,000 population, in Westchester County, just outside the borders of New York City. There, at this very time, a two weeks' enrollment drive is under way, and an intensive campaign is being carried on, to provide for every man, woman, and child in the city the opportunity to share in the benefits of prepaid hospital and medical expenses.

I understand that this campaign plan has been successfully carried out in a number of small towns in the Middle West and West, but this is the first time that a city of this size has entered upon such a voluntary project with the co-operation of all of the groups in the community. The Common Council is back of it; a non-political organization called the Yonkers Medical Care Committee, the clergy, the schools, and all of the civic organizations are promoting this citywide campaign.

It seems likely that the result will be an object lesson for the successful promotion of the widest acceptance of voluntary plans for prepaid medical care.

The opportunity is before us, in every state all over the country, to show what the voluntary plans can do. If the doctors do not act upon this opportunity, evidence that the government will enter the field is overwhelming. The hour is late. Government will not wait, because the people will not wait. People want a group prepayment program. The medical profession, their own doctors, must supply and operate a voluntary program. They will expect it. They will prefer it. As Doctors of Medicine, we should continue to control our own profession. We must act with the greatest speed, consistent with safety and orderly progress, to develop group medical care programs.

The *Detroit Free Press* on Wednesday, November 21, commenting on President Truman's proposal has this to point out regarding the medical profession:

"The important thing is that Mr. Truman has given it a choice; accept his plan or come forth with something better.

"This is the real value of his message. The medical profession has not been ruled out of the picture. It has its chance now."

There is no excuse for inaction. Leadership is our responsibility. The pattern has been built, many forms of voluntary care plans have been in existence for years—a great experience to lead you.

The success of the Michigan Plan and other plans shows what can be done by an aggressive group of physicians under the proper leadership. Executives of all present successful plans are anxious to show you the way. To fail to assume your leadership is to admit, yes, to accept defeat. If you wish to stop the extremists, who would overthrow a century of medical achievement, in the pursuit of their fantastic and impossible dreams, I advise you gentlemen to strike while the iron is hot. Develop your voluntary group medical plans today. Tomorrow, the iron may be cold and molded to a pattern not of your making and not to your liking.

HEALTH LEGISLATION BENEFICIAL TO THE PEOPLE

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TWO WEEKS ago I had in my hands the draft of remarks I proposed to make to this gathering today. But after the news emanating from Washington, I have revised what I had planned to present to you.

The change in the situation facing the medical profession today has come about so rapidly and with such great force that we must all revise our thinking and our planning. In the words of one of our leading medical journals only a few short months ago, *the time is now*. We now find our profession attacked on a broad front by politicians under the leadership of the highest elected official of our country, the President. We now face the threat of the socialization of the medical profession—even though the President and his colleagues seek to steer away from that expression—under the strongest program so far advanced by the social planners of this or any other era.

At the risk of being called provincial, may I state to you that the program now being advanced by the President is almost identical with that proposed by our Governor in California to our state legislature in January of this year. The program was the same, the same cry was raised that it was not socialized medicine; the allies of our governmental head were the same. And make no mistake about it—these allies are powerful. In California we found the American Federation of Labor linked up with the governor in his program. We found the CIO very much on that side, plus the Congress of Parent-Teachers Associations and the League of Women Voters. That is tough competition, gentlemen, but it was possible to overcome it, at least for the present.

If we handle ourselves properly now, we can do the same thing on a national scale that a handful of us were able to do in California this year. We have available to us on a national scale the same tactics, the same techniques, the same opportunities that we were able to use successfully in California.

At a meeting held in this city less than six weeks ago the word was passed along to medical leaders from all over the country that the Wagner-Murray-Dingell Bill was a dead issue. Far be it from me to question that information—it is evident that the *old* WMD Bill was dead. But it is now evident that we were being misled by Mr. Wagner and his associates, deliberately lulled into a false sense of security in order to prevent our being given a forewarning of the program that is now before Congress. We were given a little Senatorial anesthetic in order that the pain of the new body blow would be lessened. If we can keep our heads clear now, we can shake off the effects of that anesthetic and handle our own affairs in such a way that the body blow may never be landed.

Just what is behind this new Wagner-Murray-Dingell Bill? Why has the President come out in favor of this program? These questions should be uppermost in our minds because only by knowing why the other fellow is

aiming his dart in our direction can we hope to defend ourselves against his attack.

If we consider these questions for a moment we must come at once to the realization that the whole question is bound up in the fundamentals of medical economics, particularly that portion of this subject which deals with the distribution of medical care and auxiliary services. We must freely admit among ourselves that there is an uneven distribution of medical care. Some of our states enjoy four, six or ten times the amount of medical service that other states have. Some of our states have six, eight or ten times the hospital beds on a per capita basis that other states have. Even within the boundaries of our own state, some of our counties are relatively surfeited with medical service while others are starved for it. Among the various levels of our society, we all know that some groups, some income levels, enjoy adequate medical service while other groups suffer from a lack of the same service. We look around and see our splendid teaching institutions and our modern hospitals—and at the same time we see people who cannot find ready access to these facilities because of the financial barrier raised between the patient on the one side and the doctor and his appurtenances on the other. In the face of these obvious facts we must recognize the problems of medical economics raised in proposals such as those the President has just made.

Our problem—and our only problem—is to see that these medical economic questions are adequately answered in such a manner that the best elements of medical science and medical practice are maintained. We must see to it that the *quality* of medical care does not suffer in an effort to increase the *quantity* or the *availability*.

Some of our states—and our host state today, Michigan, is one of the pioneers—have taken the lead in setting up within their own borders voluntary prepayment medical care plans which lessen the shock of medical costs. We are all familiar with these plans—and we are all familiar with the fact that many of our own colleagues either will not accept such plans or enter into them in a grudging fashion which does the plans more harm than good.

Gentlemen—after the President's statement a week ago last Monday, there is no longer any room for doubt about the necessity or wisdom of providing prepayment systems for meeting medical care costs.

The only question concerning us today is the question of method. Shall prepayment be provided by voluntary means under our own sponsorship or by compulsory means under government bureaucratic standards? Does anyone present have any doubts as to the answer?

In the past year it has been my privilege to meet with many of you in various cities and to discuss this problem. It has also been my privilege to have available a large mass of information gathered by a special representative

of the California Medical Association from sources in more than half of our states as well as in several Canadian provinces. From a study of this information it is perfectly clear that the success of medically sponsored prepayment plans runs in direct proportion with the willingness of the medical profession to assume responsibility for the provision of medical service to the public on a budget prepayment basis. Where the profession has assumed this responsibility the prepayment plans have prospered and the public has been well served. Where the profession has ducked the responsibility completely—or has turned it over to the other fellow—these plans have had a mediocre growth at best.

It has always struck me as somewhat paradoxical that our profession is more than willing to assume complete responsibility for the care of the indigent but has persisted in dodging that responsibility so long as the patient has a dollar or two in his pocket. In my opinion, we as a profession must assume a joint responsibility for the medical care needs of the entire population, regardless of income status. We must take care of the middle and low-income groups just as readily as we treat the charity cases in our county hospitals.

The world has changed during our lifetimes. New economics have entered the picture, social security has become a byword and an accepted fact. It is up to us to gear ourselves and our practices into it. It is up to us to make those changes in the economics of medicine which are demanded by the times and by the people living in these times.

Again risking the charge of being provincial, let me point out to you that in California we have faced the threat of state medicine almost constantly for the past seven years. We have met that threat by undertaking to provide for the people of California a prepayment plan which we hope will have enough public appeal to be extended to so many people that there will be comparatively few of our citizens left to demand state medicine. If we had been able to move faster—and I will be the first to admit that our prepayment system has had and still has its faults—if we had been able to move faster and cover more people, we would not have had the dangerous threat which faced us and caused us so much work this year.

If the same sort of program had been prevalent all over the country—if every state in the Union had been offering a prepayment medical care plan on a basis which the average man, the wage earner, could afford to pay on a budget payroll-deduction basis, we could today have so many people enrolled in this sort of system that the plea of the President would fall on deaf ears. As it is, we have not sowed enough seed to cover the ground. Without an adequate ground covering we are beginning to be threatened by political erosion engineered by the Wagners, Murrays, Dingells and others of their kind.

Today we have a presidential program which will command strong support from many sources. It is a composite program, including not only a system of compulsory health insurance but also a hospital and medical center construction plan, aid to research, medical education and other items. Parts of it we must admit as beneficial and in keeping with our own traditions. Other parts we must reject without further ado. We can use our own judgment in selecting those parts of this program which

we will support and those parts which we will reject—but it is evident to all of us that we must take a part in the program. We must do something about it. In politics it is an old saying that you can't beat something with nothing.

Today we are forced to do something—something aggressive. The passive resistance of Mahatma Gandhi won't work if we are to preserve our freedom of enterprise.

We are certainly fortunate that our good friends from Michigan started out eight months ago to create a constructive program. Today the word of that program has spread from state to state, contributions to it have been made from all parts of the country, and it is beginning to shape up into something that we can all support and work for. Tentatively, this composite of our thinking is expressed in the principles you have already discussed and approved.

Having adopted such a set of principles, we have a constructive basis for writing legislation for introduction into Congress. Now we have something with which to fight something else and something poorer.

Let me add one more word and possibly the most serious thought which I can bring to you today. Any legislation which we may develop and which we can have introduced by some of our many friends in Congress will be utterly lost unless we implement it with the proper sort of organization. It is one thing to get a bill introduced in Congress or in your own state legislature and it is another thing to get it adopted. All of us have had experience in our own state legislative processes and I think we all realize what it takes to get bills put through when we want them passed or killed when we want them stopped. Call it pressure politics if you will, call it lobbying—call it propaganda—the fact remains that certain steps must be taken to influence legislation and to influence public opinion. We cannot afford to sit back in our ivory towers, smug in the realization that we hold the key to the medical situation and ignoring the powerful political forces which threaten to break the lock without the use of our key.

American medicine today must reorganize itself. Let me put those same words in another order—American medicine must reorganize itself TODAY. Not tomorrow or next year. It must take upon itself the responsibility for urging helpful legislation and killing harmful legislation. It must face its public relations problem squarely and do something about it. It must enter the political scene actively and forcefully. And I repeat, it must do this TODAY.

In the last few years we have seen the need for this sort of reorganization brought home to us by several organizations which have mushroomed on the edges of organized medicine. We have seen the National Physicians' Committee, the United Public Health League, the Association of American Physicians and Surgeons—we have seen these organizations blossom on fertile ground while our own medical organizations have in most instances sat by and watched them grow. These groups have not been spawned on a vacuum. They have been born and have thrived because there was a demand for the type of service they can and do perform.

In the last two years we have seen the AMA develop

a new council, the Council on Medical Service and Public Relations. And many of us have been bitterly disappointed that this Council has been so bound up in red tape or in administrative difficulties that it has not yet started to serve its real purpose. We have seen in the formation of that Council a compromise between the aggressive and the staid elements of our profession—a compromise which has resulted in a half-way project which at best can take no more than half-way measures. *Today half-way measures are not enough.*

Please don't misunderstand me. I am not blindly criticizing this new Council of the AMA. I would be the first person in the world to want to see it expand. I advocate its expansion into the voice of organized medicine in both the legislative and public relations fields. I advocate its being given authority by all of us who hold a voice and vote in the AMA to step out as the one official and officially acknowledged spokesman for organized medicine. I advocate its expansion to a point where it can take over the activities of the NPC, the UPHL, the AAPS and other organizations which today are in existence because they are needed. (*Applause*)

I advocate the operation of this Council—or of a comparable body if there is objection to this particular Council—as the proud carrier of our ideas and our thoughts to our legislators and to our people. Surely medicine can and should take pride in having a spokesman of its own, a council of its own choosing which can represent it in all those places whose representation is needed. It is high time we came out from our retirement and recognized that we are living in a society where we must make our voice heard.

I recommend to all of you that we work for the formation of just such a body as a means of implementing and giving form to the legislation which we hope to draft from our collective thinking. And when we form such a body I recommend that it in turn be implemented by giving to it everything which it needs in order to function. It needs men. It needs money. It needs prestige and it needs authority. All of these things we can give to it. We can afford the money necessary. We can lend our own support to give it prestige. We can give it

the necessary authority, properly controlled by ourselves, to carry out the program we assign to it.

As to the men it needs, two things are vital. First, we must select our men not on the basis of the degrees which they may string behind their names but on the basis of what they know, whom they know and what they can accomplish. We should spare nothing in selecting the men—we need men who can accomplish what we need and we must pay them whatever is necessary. No academic degrees are necessary—no salary is too high. We need real accomplishment. Second, we need young men. Not college sophomores but young men of brains and judgment with the flexibility and the vigor of youth. Too many times I have seen—and I know you have, too—our medical organizations operated by men too mature in years to have the punch needed in the pinches. I have been urged in my own state to continue in the administrative end of our state medical association, but I am too far advanced in years to carry on the active work that we need. There are plenty of younger men in the offing who can deliver a harder blow when it is needed and who have the brain power and judgment that we older fellows like to think we possess. There is no patent on brains and judgment but there is a definite limitation on the drive that we older men can put into an aggressive campaign. We need more youth, more vigor, more punch. The very physical beating that some of our men in California took for six months this year in fighting state medicine has proved to me that age must be recognized as a barrier if we are to fight the larger battle now being prepared in Washington.

This meeting today is one of the most stimulating gatherings that I can imagine. It brings together the real leaders of American medicine and gives them an opportunity to express themselves without the restraint that we too often find in official medical bodies. It is certainly a pleasure and honor to be able to take part in it and to bring to you a few observations based on experience and a few suggestions which I hope will eliminate in the future some of the bad experiences we have had in the past. I hope that this gathering today may bring forth the real thinking and the real program which will convert American medicine into a conscious, constructive instrument, well implemented and able to carry on into new fields of public understanding.

RESOLUTION RE HEALTH LEGISLATION

(Continued from Page 1)

service or indemnity care basis shall be incorporated under special state enabling acts or by already existing state statutes relating to non-profit producers' co-operatives. This will provide for either a prepayment or a reimbursement contractual service.

(e) Group co-operation and reciprocity, on a national level, by all voluntary state medical and hospital care (Blue Cross) programs, should be accomplished.

5. We suggest establishment in communities where feasible of a public information and educational service adequately financed, to advise all of the people with respect to proven measures to prevent illness, hygienic and sanitary measures, and where to go to seek help

when ill or injured.

6. The function of government, federal and state, should be to encourage and assist, rather than to compete with, reputable voluntary health insurance plans.

RESOLVED, That every state medical society be invited to study, adopt and activate these principles on the state level, and that they be submitted to the AMA Council of Medical Service and Public Relations for immediate consideration as a pattern for a national health program.

Upon motion this resolution was adopted without dissent.

MEDICAL PUBLIC RELATIONS

O. O. MILLER, M.D.
Louisville, Kentucky

THE TWO physicians who preceded me on this program presented you with an encouraging pattern of action in medical-economics activities. Each stressed and re-emphasized this basic idea, "*Now is the time to act.*"

I agree wholeheartedly with this admonition because I have been invited to speak on medical public relations, and any such program is subsidiary to the formulation of a plan of action on which a new public relations program can be built. This is concretely fundamental, as public relations is merely an operation to mould public opinion. A simple definition of public opinion is: what the average public thinks of you and your activities—whether they are for you or against you, indifferent to you or without opinion. This presentation is based on the premise that the medical men in our forty-eight states are acting on programs, as outlined by Drs. Howard and Gilman, designed to extend professionally controlled voluntary health protection to ALL the people. The next logical step is the development of a critically needed and well correlated program of medical public relations throughout the land.

The importance of moulding more favorably the attitude of the public towards the medical profession—so that the people understand us and the real service which we are all-too-quietly contributing to society—is appreciated by every medical leader here. Ours is a quasi-public service, and any organization (including the medical profession) that has anything to do with the public needs a well-thought-out and well-executed plan of interpreting itself to the public. But we in medicine can far less afford to inadequately interpret our work to the public than can a manufacturer of a consumer product, for the product is tangible whereas our service is less tangible and more difficult to portray. Through a sound public relations program, however, the medical profession can picture itself and its services correctly to the public. When this position has been achieved, problems arising from contacts with the public either will dissolve or offer possible easier solutions.

There is no group in existence with a greater potential force for excellent public relations than the medical profession. Patients, friends, and acquaintances all look for health and family guidance to the doctor of medicine which places him in a most enviable position. Because of his personal relationship with people, he stands on a pinnacle towering all the other professions, trades and groups. But—conversely, because of the very eminence of his standing, an individual doctor of medicine can unwittingly and easily harm the entire profession and professional standards by some example of poor public relations.

Unfortunately, the public relations effort of the medical profession as a group, not as individuals, has not been well done, if done at all, to date. None of us profess to be a public relations expert but there are certain principles that must be recognized; and consider-

able work must be done by the profession, in an attempt to give adequate expression to these fundamentals.

Principles

The medical profession, for the most part, is held in esteem by the public, but we cannot presume on that good opinion and expect them to accept our pronouncements without critical examination. The general public is far more intelligent than is generally believed and are amply capable of arriving at right conclusions when the facts are presented to them in an interesting and straightforward manner. It is not a question of what is good for us, but what is good for the public; for each individual citizen. If we can show them truthfully and in a convincing way that the social trends in medicine are pernicious and will indubitably lead to an inferior service and to a deterioration of medical standards, we may be assured of right decisions on their part.

The first principle then to stress is the absolute necessity of honesty in public relations, and in this connection, is the advisability of being factual instead of argumentative. All programs should be constructive and not merely belligerently defensive. Continuity is a most important feature in all public relations programs and none can be ultimately effective unless they are on a continuing basis. A hit and miss operation where some one sits down when the spirit moves him to write a story for the press is, of course, better than nothing, but it can't possibly be very successful. Furthermore, if we expect to be on good terms with the media for public relations, we have to play the game fairly. In other words, if the press is in receipt of something that is not on the plus side, we will fare much better with them if we co-operate in seeing that they get the story factually. If we take them into our confidence, we will find that they will also treat these stories fairly. Too often the profession misses valuable opportunities to convey opinions to the public when the press is thrown open to them. When President Truman released his five-point National Health Program, November 19, the press called six physicians in our city, each one prominent by reason of his committee appointments or personal achievement and five out of the six had no comment to make to the press or the public at large. What must the public think, when we are silent on the most vital issues of the day? Surely we can have an opinion on (1) Federal aid for the construction of hospitals and health centers. (2) Expansion of public health and, especially, the Maternal Infant Care Bill in its present form. (3) Federal aid for more adequate professional education and research on the cause, prevention and cure of cancer and mental illnesses. Here was an opportunity to endorse the good features and point out the bad and dangerous provisions of the program.

Another thing that must be registered: anything that Washington does is news and finds its way almost automatically into the newspapers. We will never reach a

favorably competitive position with them until we have developed the proper favorable relationship with the sources of publicity, either locally or nationally. On the other hand, working from the local level up, we are in a better position to cultivate the sources of publicity than are the people in Washington:

Plan of Action

In considering a plan of action it is manifest that if there are forces which are active in attempting to mould public opinion in a way which is not good for us, or for the public, we cannot very well counteract this activity until we get into action ourselves.

The action pattern should be on the State level. Too few county medical societies in this country have the finances or the administrative personnel to conduct a successful and sustained public relations program. Our aim should be towards a concerted plan of national coverage, rather than one which dissipates energy and funds in spotty projects here and there in several states.

State medical societies must assume responsibility for a public relations program on behalf of the medical profession. If their reserves are not sufficiently ample to cover the costs of such an important function, they should raise their dues or levy special assessments on their members at once for this specific purpose. After all, it is for the immediate benefit of the individual member of the State Society and he should be willing to contribute a few dollars and write them off as a business expense in his income tax report.

The State Society Program of Public Relations, or health education of the public, can well profit by the Survey of Public Opinion, such as California and Michigan sponsored in 1944, or they may elect to make their own survey to know just what their own state program should include; but generally speaking, the following may be considered as important items in any such undertaking, regardless of individual or geographical problems.

The public relations program of a State Medical Society should include:

1. Employment of a full-time secretary or Public Relations Counsel, in the Executive Office, who shall
 - (a) Prepare news releases.
 - (b) Contact newspapermen (all dailies and weeklies) in their home communities.
 - (c) Contact labor and industry.
 - (d) Contact individually the federal congressmen and state legislators in their home communities. Send them periodic letters stressing the value of private medical practice (and aided by voluntary plans) as contrasted to compulsory political control.
 - (e) Arrange educational conferences for lawmakers, business and insurance leaders, and others interested in public health.
 - (f) Stimulate and develop newspaper advertising for county medical societies.
 - (g) Develop booklets and printed material showing benefits of American Medicine and private practice, aided by voluntary pre-pay group health care programs.
 - (h) Aid in script writing of commercial radio and movie programs.
 - (i) Arrange for presentation of addresses, to lay groups, covering the medical profession.
 - (j) Aid in organizing the Woman's Auxiliary to take

an active part in any activity to preserve private enterprise.

2. The program should include the sponsorship of group medical care programs in States where they do not exist, or aid in the maximum expansion of programs now operating.
3. Urge a program of "Best health care for the veteran" by use of local facilities and the physician-patient relationship and participate in clinics designed to render service to the veteran.
4. Inaugurate medical commercial radio and medical motion picture programs.
5. Furnish leadership to county societies in regard to their public relations activities, especially those of a local character.
6. Provide stimulation and leadership in the development of a state health council and its public relations program. We must encourage, recognize, and utilize all non-governmental agencies formed to advance the health of the people—such efforts on the state level as health leagues and health councils.
7. Co-operation with other States in the formation of a National Health Congress.

Other items in your public relations program—to meet needs for information to the people—will be more or less defined by your knowledge of your own requirements. If you contemplate a survey this will give you factual data and will show what are the "pet peeves" of the public or, in other words, what faults must be corrected by the medical profession before any public relations program, no matter how good, can be wholly effectual. For example, one State Society's survey brought out this enlightening information: despite the fact that 91.6 per cent of the people of that particular state felt that Doctors of Medicine as a group were held in the highest esteem, and were doing a good job for the public; 6.5 per cent felt the doctors overcharge; 4.4 per cent complained that physicians kept patients waiting; 1.7 per cent are of the opinion that doctors lack interest in their patients; and 5.6 per cent felt that doctors are dishonest. While this percentage was not high, the elimination of such complaints is the first responsibility of every individual practitioner of medicine and the medical profession as a whole.

To reiterate: if our own house is in order, then all we have to do is to present our story in a straightforward and interesting manner and the public will be with us and not with those who would thrust on the people's neck the costly and inefficient yoke of compulsory political medicine.

We have much to tell. The glorious story of what Medicine has done, is doing, and intends to do will be fascinating in the unfolding, and it *must* be told by the medical profession—State by State—at once.

As physicians we might well remember that governments may fall, political parties may dissolve, but Medicine will go on forever. However, it is our serious and first responsibility to keep Medicine a free science, unchained and untrammled. We must keep American Medicine, what it is today, the best in the world, and we must begin to tell and keep on telling the people more and more about our work, our trials, our successes, our failures—yes, about us.

Gentlemen, time is of the essence: Now is the time to act!

FORMATION OF A NATIONAL HEALTH CONGRESS

JOHN F. HUNT

Vice President, Foote, Cone & Belding
Chicago, Illinois

FOR REASONS which I think many of us will accept, I think it might have been appropriate to start this meeting by asking all of you to stand up—face the East—that's the direction of Washington from Chicago) and bow your heads for the customary thirty seconds, in mute tribute to the social crusaders whose brain child is the Wagner-Murray-Dingell Bill. (*Laughter and applause*)

I would assume that there are few, if there is one single man, in this audience who would vote for this bill were you sitting in the Senate or the House when it comes up for consideration. I am equally sure that there is not a man in this room who is not entirely in favor of the purported over-all objective of this bill, that is, adequate health care for *all* the people of this nation through a comprehensive health plan.

You and your associates have devoted your lives to making and keeping people well. It is logical, therefore, to assume that you would be more interested, more enthusiastic about complete health for all the people than are those individuals or groups who would force it by government action.

And yet, unfortunately, with all your magnificent health contributions, with all your personal sacrifices, and all your professional enthusiasm, you have done nothing to bring about the universal health condition which would make government action patently unnecessary and completely unattractive to the public as a whole.

You may or may not know the temper of the American people on this very important question. You may think that the public has no opinion on the subject of health protection for *all* the people. Well, the public very definitely has. Boiled down, it is simply this: The public knows the value of health; the public wants health, and the public is determined to get it one way or another. If the private health forces do not provide it for them, they will accept a health plan from the government. This is not just my opinion, but is the conclusion that must be drawn from every honest survey that has been made on the subject.

But the green light is still on for voluntary health care. The public would prefer a health plan under voluntary administration to a plan controlled and administered by either state or federal government, if you make it possible for them to have it. All the surveys that we have studied, including the two that we ourselves made in the states of California and Michigan prove conclusively that when the public is given a *choice* of alternate plans the majority will invariably select a voluntary plan to one which is state or federally controlled.

But, unfortunately again, the public to date has no choice on a national basis. The only complete coverage plan being offered to the people is that proposed by government under the Wagner-Murray-Dingell Bill.

There has been a great deal of excitement and con-

versation in medical and health circles about the situation which confronts you. There has been a great deal of what I call negative and belligerent publicity against the position the government intends to take and specifically against the Wagner-Murray-Dingell Bill. I would like to say to you that that in the end will avail you nothing. Too many of our intelligent doctors have been running around trying to put out a 5-11 fire with squirts from their own little hypo needles. You can't put out a fire that way—not this kind of a fire. As a matter of fact, the flames fan daily hotter and hotter. Each gust of Washington air pushes them a little higher. You had a beautiful guest on the 19th of November!

You gentlemen are realistic people. You have to be in your profession. Doesn't it seem sensible then to bring to the diagnosis of your own problem the same intelligent, factual, down-to-earth thinking that you apply to the condition of your patients. If you do this, then you must agree that you have no cure for your problem until you offer the American public on a voluntary basis a health plan as comprehensive and as attractive as that which the proposed government legislation would ostensibly bring to the public.

And let me remind you, in your realistic approach to curing your patients, you don't say, "I've thoroughly diagnosed this case, I know where the trouble is—and some day next month or next year or maybe some time in the hazy indefinite future—when I get around to it—I'm going to give him some medicine." No, you don't do that with other people's ills. As soon as you have located the seat of the trouble *you go into action*.

You must follow the same strategy if you are to save free enterprise in health care. You must start now. The National Health Congress is offered to you as a plan for action!

We believe that in the National Health Congress the medical and allied health professions can give the public a plan which under voluntary control will not only offer, but will actually accomplish all and eventually more than is promised the public under the provisions of the Wagner-Murray-Dingell Bill.

What is the National Health Congress?

It is still an idea. Before suggesting initial steps to bring it out of the idea stage into tangible reality, it may be sensible to re-define and to re-assay it even for this audience.

Briefly, then, the National Health Congress, as proposed, is a plan or method for voluntary merging or coordinating the abilities and facilities of all the voluntary health forces. Its purpose is to make available to every individual in this nation complete health care coverage through voluntary means at a cost the public can afford to pay. Its further purpose is to raise even higher the high standard of health care already existent in this country by preserving, free and undominated,

those forces which have made this nation the healthiest on the globe.

Why is the National Health Congress now proposed?

The reason is completely obvious. It is not possible for any one segment of the voluntary health forces to accomplish alone what the government proposes to give to all the people. It is true that individual activities such as the flourishing Blue Cross Hospital Plans and the growing medical plans can take care of certain portions of the health necessities of our people. Alone, they do not go far enough. None of them is so constituted that they can possibly encompass all of the activities that necessarily must be included in a completely comprehensive health coverage plan for all the people. The only possible answer is co-ordination of all the health professions' abilities and facilities. You and your associates in the health picture are the very means which the government plans to use in order to effect the health package which is to be offered by government to the public. You are the tools that must be used by anyone—yourselves or government—if this very laudable project of bringing health care to every citizen of this nation is to be accomplished.

You and the public can put these same tools to work in a voluntary plan if you agree to co-operate and co-ordinate all your abilities. The blueprint is right in front of you. You can either elect to build your own house or have government build it for you—and naturally I should add—run it for you. There is no alternative. Either you do this within a reasonable period of time, or the government of necessity will step in and do it—with or without your blessing. The people must be served. It is the function of government to see that the people *are* served. If by your own activities you make it clearly unnecessary for the government to take action, then you will have a solid position in the people's court. The public will be for you and of necessity the government must be for you, because in the final analysis the government is the people.

Is the idea of a National Health Congress perfect?

No, I am sure it is not. I don't believe that anyone would contend that it is. Nothing as big as this could possibly achieve perfection in its first draft. But it is a basically sound concept of how you must organize to do what you have to do. The Constitution of the United States when drafted was as good as the Founding Fathers could make it. In the years that followed it has come to be considered not only here but throughout the world as being on the perfection side, but I needn't tell you that this document has seen some twenty-two amendments since it was first accepted to meet the conditions that prevailed in the original thirteen states.

I would like to say again, no, the idea of a National Health Congress as proposed is not perfect. It is up to you gentlemen to make it perfect.

Is the concept of a National Congress too big?

No. I believe I adequately answered this a few minutes ago by stating categorically that you can only

build the voluntary answer to the government challenge by being big. There are a great many people who are constitutionally afraid of ideas that are beyond their own little realms. But again I would like to say to you that you have no alternative. When the problem is big the solution must also measure up. If you admit that the necessary merger of voluntary forces to provide health protection for all the people is impossible you admit defeat for the voluntary forces. In that case it would be more sensible to forget your devotion to voluntary health service and let the government do the job. That ostensibly again you would not be big enough to do.

Would the National Health Congress be too unwieldy?

We believe not. As proposed, the National Health Congress provides for elected or appointed representatives of each division of the professional health forces, plus industry, labor, agriculture in each of the forty-eight states, plus one seat each for the United States Senate, House of Representatives, and the United States Public Health Service. This makes 387 members. We will agree that this is a fairly large organization, but if you are to put together a completely democratic body to evolve a sound health plan for the nation under voluntary means, you will of necessity wind up with a rather large organization. Obviously, there is no one group or organization of people here you can leave out. You can't leave medicine out, you can't leave out the hospital people. They are in, too. All the way down the line. The dentists are pretty much back in the woods, it seems to me, but you are going to have a completely comprehensive plan and you will have to bring the dentist in and the nurses and the pharmacists and there are more. Numbers also do not of necessity mean confusion and turmoil. This fairly large body of men would work by committees—just as our national legislative congress works, and that body succeeds in getting things done. You may not like all the things they do, but you must admit that there is plenty of evidence of activity. If the voluntary health people adopt this proposal maybe at some later date a way may be found to streamline the National Health Congress into a more compact group. This would be possible, for instance, if all states were organized under their own state health councils, but this condition does not yet exist.

Several sentences ago, I mentioned our national legislative congress and asserted that it gets a lot done. Quite rightly, the thought may have occurred to you, "Yes, but they have all year to do it." This is true. It is also true that a large voluntary organization like the National Health Congress cannot be in session for long periods of time. Perhaps a total of a week or ten days out of each year may be the limit which the members can afford to be away from their own practices or their own businesses. This has been recognized. The suggested structure of the Health Congress makes provision for this.

On my right is a chart of how the National Health Congress might be organized. You may want to examine this more closely at the close of the meeting, but I'd like to give you a brief explanation, particularly in view of

the assertion that getting the work of the Congress done has been provided for.

The whole operation naturally revolves around the national body. Full representation is provided for the professional divisions—medicine, dentistry, nursing, pharmacy, medical prepayment plans, hospital prepayment plans, as well as representation for the consumer through agriculture, business and labor. Government is also in the picture because any public service operation of this nature and scope needs the contribution of the government. This is particularly true in the case of national health. Certain segments of our society—veterans, the indigent, the mentally ill are natural wards of the government. Their health care should be underwritten by the government.

The congress would do much of its work through councils either appointed or chosen from the delegates making up the large body. The number of councils would depend on the number of logical main divisions of the whole health problem.

The individual councils in turn would appoint committees to completely surround every aspect of the whole subject assigned to them. They would report back to their council which would present full data and recommendations to the congress.

In order to further expedite preliminary study and analysis and to provide for the execution of the decisions of the congress a permanent administrative staff is recommended. This would be headed by an executive director appointed by the congress. He would select as his key assistants competent men to direct the work falling under these divisions: Medical Service, Hospital Service, Dental Service, Nursing Service, Public Relations, Industrial Relations, Labor Relations, Farm Relations. It is recommended that the whole voluntary structure be further tightened up by the rapid inauguration of state health councils wherever they do not now exist. These state councils should be given the job of execution of the plans of the council at the state level. They should be the liaison between their National Health Congress, their own states' professional bodies, and the public, made up of agriculture, business and labor, plus their state governments.

Will the National Health Congress appeal to the consumer—agriculture, business, labor?

The answer is definitely yes, provided these groups are asked to become partners with you in the whole enterprise and provided they are *assured* that this Congress is *honestly* set up to whip the health problem for *all the people* and will not become a tool of the medical profession engineered to further selfish medical interests.

On my left is another exhibit showing excerpts from letters received from industrial and agricultural leaders in response to a mailing which briefly outlined the National Health Congress proposal. * You may think we picked the best letters out. There were some letters that were negative. You always find some letters that are negative on any subject. But, out of all the letters we received, I would like to read you a few typical com-

ments. This letter was selected as the centerpiece. It is from the President of the Allis Chalmers Company in Milwaukee. It doesn't say a terrific amount without knowledge of the attachments. The attachment was a five-page letter, if I remember correctly, which outlined the complete medical situation, the political situation which gave a pretty good criticism and an analysis of the National Health Congress as originally proposed.

This is from Mr. Geist:

"Dr. Brunk,

"I have had occasion to discuss with a number of people the subject of the paper, 'Will Private Enterprise Survive in Medicine?', sent to me with your letter of June 5. The comments of Dr. Karl Eberbach which are enclosed expresses better than I can, the consensus of opinion of the people I have talked to. If you have occasion to distribute further information or literature on this very vital subject, I would be pleased to receive it from you."

This has an excerpt pulled from it: "The best solution yet offered out of all the words and plans that have come forward in the past ten years is the National Health Congress."

This is from Ralph Budd. This is a quote from it. "I greatly hope that the medical profession will see the importance of organizing a National Health Congress." Mr. Budd wrote Dr. Brunk several letters. He wants to be continually informed of what is going on.

This is from Mr. Simmons, President of the Simmons Company which is the biggest thing in bedding and beds.

"Frankly, I agree with you that the first and most crying need of the profession is one over-all organization such as the National Health Congress."

This is from Robert H. Reed, the editor of the *Country Gentleman* magazine, one of the most important farm papers in the United States. He says, "I am impressed with the simple good sense of the National Health Congress."

Here is a letter from A. B. Dick, President of the A. B. Dick Company. He founded a hospital out in Lake Forest and gave them all the money so you can imagine he has some concept of what hospitalization is and what health is about. He says, "The National Health Congress will attack the matter constructively. I would thoroughly endorse the effort."

This is from Hugh Curtiss, Managing Editor of *Successful Farming*. He says: "Some voluntary group such as the National Health Congress is a vital necessity. We wish you every success and hope we may help you editorially."

Here is one from Benjamin E. Young, a hardhearted banker from Detroit. He says: "I can offer no better solution than the National Health Congress."

This is from George Smith, President of Johnson and Johnson. He ought to have some idea of the problem confronting medicine. "It is clear unless a practical plan is developed and efficiently presented, we must anticipate government intervention."

This is from Louis H. Nichols of Bauer and Black. I think he is one of the best posted men in that field. "I am heartily in favor of the basic idea. I think I

would put even more emphasis on the need for very prompt and aggressive action."

These replies showed a great deal of interest; they posed some of the questions which I hope I have fairly well answered. In the main they were *hopefully* enthusiastic about the National Health Congress idea.

Speaking as a self-appointed representative of business, I think I may say to you, with no fear of being accused of even slight exaggeration, that—if this congress is put together as proposed on a completely unselfish basis—business will welcome it with open arms. Business is conscious of the problem and interested in doing what it can to solve it through voluntary, democratic means. Witness the twenty million people covered by the ten million hospital service contracts, the vast majority of which are activated by payroll deductions. The cost of many of these contracts, as you know, is entirely absorbed by employers. Many more are written on a 50-50 cost basis. Industry will gladly co-operate, because industrialists are not nearly as flint hearted as some people would make them out. Industry would gladly join you because industry is fervidly interested in keeping free enterprise the keystone of American progress.

Their interest—again provided this congress is built right—will be matched by the country's outstanding farm leaders. There is plenty of evidence on which to base this assertion. You have just been read excerpts from a couple of letters from two of the top men in the farm field. Incidentally, we have all of the letters that any of us received. They are all here. Anybody who wants to look at them can look at them; the positives and thank God! just a few negatives.

Labor? As you know, labor has declared itself as favoring the Wagner-Murray-Dingell Bill. Labor is the most vocal group in clamoring for truly national health care. They want it and are determined to get it. From what I know about the thinking in labor circles, I believe it is safe to say that labor is backing the Wagner-Murray-Dingell Bill because labor has despaired of ever getting a comprehensive health plan on a national basis from the voluntary forces. I further believe that if this congress is established as proposed with labor properly positioned in it, the voice of labor will be singing in your chorus instead of doing its strident solo in the other choir.

Will the National Health Congress interfere with the existing professional organizations (both your national and state organizations)?

This question can be answered in a very few words. It would not only *not* interfere, but we believe it would be actually beneficial. By providing a truly national stage for medicine, by utilizing all the abilities of the present organizations, and making it possible for them to be further extended, it would make any existent sound organization more useful to its members as well as to society as a whole. The only people that are presently interested in the current organization, that need to be afraid of this idea at all as interfering with their activities are those—if there are any and I don't know any—that are unsound and in that kind of an organization, it doesn't deserve to live anyway. It ought to be out of your ken and out of your picture because it can only do you harm.

What can you do to bring the National Health Congress out of the idea stage and into action?

Somebody has to start this thing. Some group must put a lever under the ball to get it rolling. While this proposal will not emerge as an organization *by* and *for* the medical profession, it is thoroughly logical that the medical profession should give it its start. If you are convinced that the voluntary forces can put together a plan which will completely take care of the health needs of *all the people*, if you are convinced that this National Health Congress proposal is basically sound and workable, then we believe you should reach out for this idea and take it into *Action*.

And I mean action *now* for the time is short unless you are willing to sit supinely by and see the health of the nation and your own profession *sold short*.

The National Health Congress needs your endorsement. It needs the endorsement of the American Medical Association. It needs incorporation to make it a "going business." If you two organizations will grab this banner you can lead the greatest health progress parade this nation has ever seen. I say *parade*, because I am confident that you will have an immediate consumer following if you just begin to show by not words but action that you, too, have both a *concept* and an *appreciation* of the necessity of bringing health protection to *all the people*; if you begin to show by not words alone but action that the voluntary forces are big enough to accept the challenge which is being politely but firmly thrown into your faces by the national government.

May I suggest that this membership initiate at this meeting the action that is *needed now*. There is no better way to erect a truly glorious monument to this First Annual Conference of Presidents.

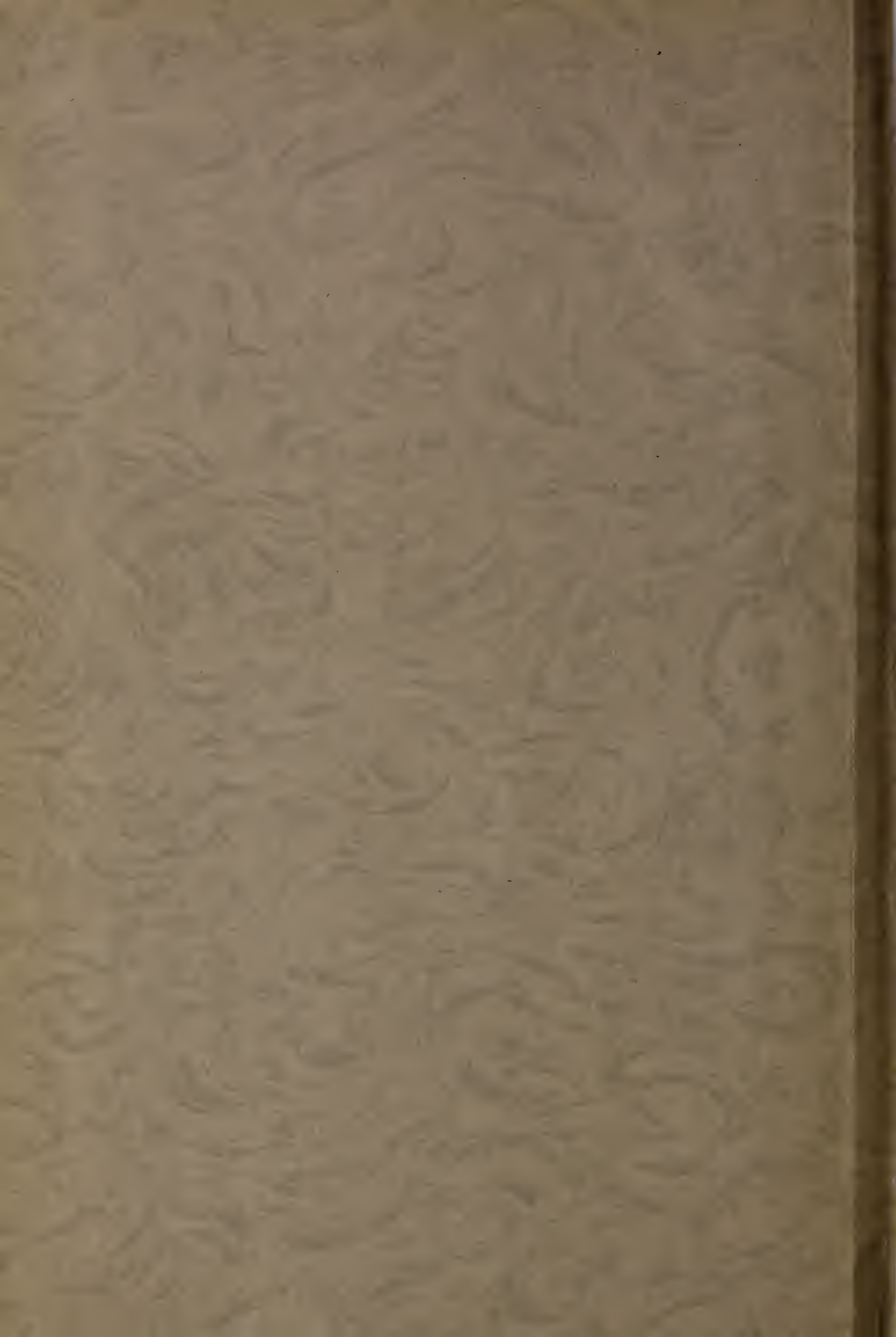
ADEQUATE HEALTH SERVICE

(Continued from Page 6)

result of over thirty years of experience with health insurance, is wholeheartedly in favor of the principle of compulsory health insurance. Indeed, it has assumed leadership in demanding that the present health insurance system be made more comprehensive in terms of persons covered and services provided. Likewise, the Canadian Medical Association has gone on record as favoring the principle of compulsory health insurance.

Co-operation Between Medical Profession and Government

May I express the hope that in this country, regardless of differences of opinion that may exist on general policies or on important details, the organized medical profession and the Government will join hands in undertaking to work out a constructive solution for the problem of assuring adequate health service for all the people.



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